

Compass Rose Health Plan

www.compassrosebenefits.com

[Customer Service 1-877-531-1159](tel:1-877-531-1159)



2013

A fee-for-service plan with a preferred provider organization

Who may enroll in this Plan: Civilian Active and Retired employees of the following organizations:

Office of DNI (ODNI) and Affiliated Centers
Central Intelligence Agency (CIA)
Defense Intelligence Agency (DIA)
Department of Defense/ Civilian and Civilian Retirees (DOD)
Department of Energy, Office of Intelligence and Counterintelligence
Department of Homeland Security, Office of Intelligence and Analysis
Department of Treasury, Office of Intelligence and Analysis
Drug Enforcement Administration, Intelligence Division
Federal Bureau of Investigation (FBI)
National Geospatial-Intelligence Agency (NGA)
National Reconnaissance Office (NRO)
National Security Agency (NSA)
Office of Naval Intelligence
Department of State

Membership dues: There are no membership dues.

Enrollment codes for this Plan:

421 – Self Only

422 – Self and Family

IMPORTANT

- Rates: Back Cover
- Changes for 2013: Page 14
- Summary of benefits: Page 90



Authorized for distribution by the:



United States
Office of Personnel Management

Healthcare and Insurance
<http://www.opm.gov/insure>

RI 72-007

**Important Notice from Compass Rose Health Plan About
Our Prescription Drug Coverage and Medicare**

OPM has determined that the Compass Rose Health Plan's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15th through December 7th) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). (TTY 1-877-486-2048).

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Introduction

This brochure describes the benefits of the Compass Rose Health Plan's contract (CS 1065) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 1-877-531-1159 or through our website: www.compassrosebenefits.com. The address for the Compass Rose Health Plan administrative office is:

Compass Rose Health Plan

P.O. Box 141501

Nashville, TN 37214

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2013, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2013, and changes are summarized on page 14. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; “we” means Compass Rose Health Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanation of benefits (EOBs) statements that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

• If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-877-531-1159 and explain the situation.
- If we do not resolve the issue:

<p style="text-align: center;">CALL – THE HEALTH CARE FRAUD HOTLINE</p> <p style="text-align: center;">877-499-7295</p> <p style="text-align: center;">OR go to www.opm.gov/oig</p> <p style="text-align: center;">You can also write to:</p> <p style="text-align: center;">United States Office of Personnel Management Office of the Inspector General Fraud Hotline 1900 E. Street NW Room 6400 Washington, DC 20415-1100</p>

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That’s about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking with.
- Take a relative or friend with you to help ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosages that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:

"Exactly what will you be doing?"

"About how long will it take?"

"What will happen after surgery?"

"How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications you are taking.

Patient Safety Links

-www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety, but to help choose quality health care providers and improve the quality of care that you receive.

-www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

-www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about safe, appropriate use of medicines.

-www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

-www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use Compass Rose Health Plan preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures, and reduce medical errors that should never happen called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition prior to enrollment.

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, give you a *Guide to Federal Employees Health Benefits*, brochures for other plans, and additional materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment
- How you can cover your family members
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
- What happens when your enrollment ends
- When the next open season for enrollment begins

We don't determine who is eligible for coverage and in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of any changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan

If you have a Qualifying Life Event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/insure/lifeevents. If you need assistance, please contact your employing agency, personnel/payroll office, or retirement office.

• **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural, adopted children, and stepchildren	Natural, adopted children, and stepchildren are covered until their 26 th birthday.
Foster Children	Foster children are eligible for coverage until their 26 th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married Children	Married children (but NOT their spouse or their own children) are covered until their 26th birthday.
Children with or who are eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/insure.

• **Children’s Equity Act**

OPM has implemented the Federal Employees Health Benefits Children’s Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan’s Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan’s Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2013 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2012 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

When FEHB coverage ends

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31-day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension, is entitled to continuation of the benefits of the Plan during the continuation of the confinement but not beyond the 60th day after the end of the 31-day temporary extension.

You may be eligible for Spouse Equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

Upon divorce

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the Spouse Equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Employees Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Website, www.opm.gov/insure.

Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 26, regardless of marital status, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

Converting to individual coverage

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the Spouse Equity law ends (if you cancelled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the Spouse Equity law; or
- You are not eligible for coverage under TCC or the Spouse Equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Website at www.opm.gov/insure/health; refer to the “TCC and HIPAA” frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 1. How this plan works

This Plan is a fee-for-service (FFS) Plan. You can choose your own physicians, hospitals, and other health care providers.

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

We have a Preferred Provider Organization (PPO)

Our fee-for-service plan offers services through a PPO. This means that certain hospitals and other health care providers are “preferred providers.” When you reside in the PPO network area and use our PPO providers, you will receive covered services at a reduced cost.

The Plan uses the United Healthcare Options PPO network in all states.

To access the electronic directory visit www.compassrosebenefits.com. From the left side of the home page, scroll over HEALTH PLAN, then scroll down to CRHP, then click "find a doctor." Also, when you phone for an appointment, please verify that your physician is still a PPO provider. Contact us at 1-877-531-1159 for information concerning your PPO.

PPO benefits apply only when you reside in the PPO network area and use a PPO provider. **You must present your PPO identification (ID) card confirming your PPO participation to be eligible for PPO benefits.** Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply. If they are not they will be paid as non-PPO providers. When you use a PPO hospital, keep in mind that the health care professionals who provide services to you in the hospital, such as radiologists, emergency room physicians, anesthesiologists, and pathologists, may not be preferred providers in our PPO. We will provide the PPO benefit level for the non-PPO providers, however their respective charges will be subject to the Plan allowance as defined in Section 10.

If you reside in the PPO network area and no PPO provider is available, or if you do not use a PPO provider, non-PPO benefits apply.

How we pay providers

Our participating providers are generally reimbursed according to an agreed-upon fee schedule and are not offered additional financial incentives based on care provided or not provided to you. Our standard provider agreements do not contain any contractual provisions that include incentives to restrict a provider’s ability to communicate with and advise patients of any appropriate treatment options. In addition, the Plan has no compensation, ownership, or other influential interests that are likely to affect provider advice or treatment decisions.

We may, through a negotiated agreement with some non-PPO health care providers, apply a discount to covered services that you receive from these providers.

To locate a non-PPO provider from whom a discount may be available, call the number on the back of your identification card.

We use Milliman Care Guidelines and Physician Peer Review criteria in making determinations regarding hospital stay precertification and extended stay reviews, observation stay reviews, and reviews of procedures that require precertification or authorization. (See *How you get care* in Section 3.) These determinations can affect what we pay on a claim.

We apply the National Correct Coding Initiative (NCCI) edits published by the Centers for Medicare and Medicaid Services (CMS) in reviewing billed services and making Plan benefit payments for them.

Your rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our network, and our providers. OPM’s FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

If you want more information about us, call 1-866-368-7227 or write to Compass Rose Health Plan P.O. Box 8816 Reston, VA 20195. You may also contact us by fax at 703-438-0840 or visit our Web site at www.compassrosebenefits.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Section 2. Changes for 2013

Do not rely on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- Removed annual limits on essential health benefits as described in section 1302 of the Affordable Care Act.
- Plans must provide coverage for routine patient costs for items and services furnished in connection with participation in an approved clinical trial.
- Coverage with no cost sharing for additional preventive care and screenings for women provided in comprehensive guidelines adopted by the Health Resources and Services Administration (HRSA).
- Alaska and Kentucky were designated as a Medically Underserved Area in 2012, but will not be designated for 2013. South Carolina is being added as a Medically Underserved Area for the 2013 calendar year.

Changes to this Plan

- There is a rate **increase** for plan year 2013, please see back of brochure.
- The Plan will increase primary care physician copays to \$15 and specialist copays to \$25 per office visit.
- The plan will increase inpatient hospital admission copay to \$200 in-network and \$400 out-of-network.
- The Plan will increase the calendar year deductible to \$350 in-network and \$400 out-of-network.
- The plan will cover Maternity at 90% of the plan allowance, no deductible.
- The plan will increase the Non-Medicare retail prescription drug copays for tier 2 to \$35 and tier 3 to 30% or \$50, whichever is greater.
- The Plan will increase the Non Medicare mail order prescription drug copays for tier 2 to \$70 and tier 3 to 30% or \$100, whichever is greater.
- The Plan will require bariatric surgery to be performed at a UnitedHealthcare Bariatric Centers of Excellence.
- The Plan will pay 100% for generic oral contraceptives with a physician prescription. (If generic is unavailable, you pay nothing.)
- The Plan has made benefit clarifications/modifications to hospice care, infertility, nutritional counseling, augmentative and alternative communication devices and wigs.
- The Plan will cover one pair of diabetic shoes per person with an annual replacement.

Section 3. How you get care

Identification Cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-866-368-7227 or write to us at Compass Rose Health Plan P.O. Box 8816 Reston, VA 20195. You may also request replacement cards to be sent to you through our Web site: askcrbg@compassrosebenefits.com.

Where you get covered care

You can get care from any “covered provider” or “covered facility”. How much we pay – and you pay – depends on the type of covered provider or facility you use. If you use our preferred providers, you will pay less.

• Covered Providers

We consider the following to be covered providers when they perform services within the scope of their license or certification:

Physician: Doctors of medicine or psychiatry (M.D.), osteopathy (D.O.), dental surgery (D.D.S.), medical dentistry (D.M.D.), podiatric medicine (D.P.M.), chiropractic (D.C.), and optometry (O.D.) when acting within the scope of their license or certification.

Qualified Clinical Psychologist: An individual who has earned either a Doctoral or Master's Clinical Degree in psychology or an allied discipline and who is licensed or certified in the state where services are performed. This presumes a licensed individual has demonstrated to the satisfaction of state licensing officials that he/she, by virtue of academic and clinical experience, is qualified to provide psychological services in that state.

Nurse Midwife: A person who is certified by the American College of Nurse Midwives or is licensed or certified as a nurse midwife in states requiring licensure or certification.

Nurse Practitioner/Clinical Specialist: A person who 1) has an active R.N. license in the United States, 2) has a baccalaureate or higher degree in nursing, and 3) is licensed or certified as a nurse practitioner or clinical nurse specialist in states requiring licensure or certification.

Clinical Social Worker: A social worker that 1) has a Master's or Doctoral degree in social work, 2) has at least two years of clinical social work practice, and 3) in states requiring licensure, certification or registration, is licensed, certified, or registered as a social worker where the services are rendered.

Speech, Occupational and Physical Therapists: A professional who is licensed or meets state requirements where the services are performed to provide Speech, Occupational or Physical therapy services.

Physician Assistant: A person who is licensed, registered, or certified in the state where services are performed.

Licensed Professional Counselor or Master's Level Counselor: A person who is licensed, registered, or certified in the state where services are performed.

Audiologist: A person who is licensed, registered, or certified in the state where services are performed.

Licensed Acupuncturist (L.A.C.): A person who has completed the required schooling and licensure to perform acupuncture in the state where services are performed (see definition of acupuncture benefits, Section 5(a)).

Christian Science Practitioner: If you choose to visit a Christian Science practitioner instead of a physician, the charges are still considered allowable expenses. To qualify for benefits, you must make this choice annually. The benefits will then apply to all subsequent expenses incurred during the year. You can change your mind only at the time of your first claim each year. The practitioner you choose must be listed as such in the *Christian Science Journal* that is current at the time the service is provided. Your choice will not apply to, or prevent payment of, a physician's maternity charges.

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in the states OPM determines are "medically underserved". For 2013, the states are: Alabama, Arizona, Idaho, Illinois, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, Oklahoma, South Carolina, South Dakota, and Wyoming.

• **Covered Facilities**

Covered facilities include:

- Hospital

1) An institution that is accredited as a hospital under the hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or

2) Any other institution that is operated pursuant to law, under the supervision of a staff of doctors with 24-hour-a-day nursing service, and that is primarily engaged in providing:

a) General patient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which facilities must be provided on its premises or under its control; or

b) Specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including x-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those facilities.

3) For inpatient and outpatient treatment of mental health and substance abuse, the term hospital also includes a freestanding residential treatment center facility approved by the JCAHO or Commission on Accreditation of Rehabilitation Facilities (CARF).

In no event shall the term hospital include a convalescent nursing home or institution or part thereof that:

- is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged;
- furnishes primarily domiciliary or custodial care including training in the routines of daily living;
- or is operated as a school.

Nursing School Administered Clinic: A clinic that is

- licensed or certified in the state where the services are performed, and
- provides ambulatory care in an outpatient setting—primarily in rural or inner city areas where there is a shortage of physicians. Services billed for by these clinics are considered outpatient 'office' services rather than facility charges.

Skilled Nursing Facility: An institution, or the part of an institution that provides convalescent skilled nursing care 24 hours a day and is classified as a skilled nursing facility under Medicare.

Birth Center: A licensed facility that is equipped and operated solely to provide care, to perform uncomplicated spontaneous deliveries and to provide immediate postpartum care.

Hospice: A facility that meets all of the following:

- 1) primarily provides inpatient hospice care to terminally ill persons;
- 2) is certified by Medicare as such, or is licensed or accredited as such by the jurisdiction it is in;
- 3) is supervised by a staff of M.D.'s or D.O.'s, at least one of whom must be on call at all times;
- 4) provides 24-hour-a-day nursing services under the direction of an R.N. and has a full-time administrator; and
- 5) provides an ongoing quality assurance program.

• **Transitional care**

Specialty care: If you have a chronic or disabling condition and

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan, or
- lose access to your PPO specialist because we terminate our contract with your specialist for reasons other than for cause,

you may be able to continue seeing your specialist and receiving any PPO benefits for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist and your PPO benefits continue until the end of your postpartum care, even if it is beyond the 90 days.

• **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-877-531-1159. If you are new to the FEHB Program, we will reimburse you for your covered expenses while you are in the hospital beginning with the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center;
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

The pre-service claim approval processes for inpatient hospital admissions (called precertification) and for other services, are detailed in this Section. A **pre-service claim** is any claim, in whole or in part, that requires approval from us in advance of obtaining medical care or services. In other words, a pre-service claim for benefits (1) requires precertification, prior approval or a referral and (2) will result in a reduction of benefits if you do not obtain precertification, prior approval or a referral.

• **Inpatient hospital admission**

Precertification is the process by which —prior to your hospital admission —we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition. Unless we are misled by the information given to us, we will not change our decision on medical necessity.

In most cases, your physician or hospital will take care of requesting precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital if they have contacted us.

WARNING:

We will reduce our benefits for the inpatient hospital stay by \$500 if no one contacts us for precertification. If the stay is not medically necessary, we will only pay for any covered medical services and supplies that are otherwise payable on an outpatient basis.

Exceptions

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States.
- You have another group health insurance policy that is the primary payer for the hospital stay.
- Medicare Part A is the primary payer for the hospital stay. Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we will become the primary payer and you do need precertification

• **Other services**

Some other services require precertification or prior authorization. Call 1-877-531-1159 for prior authorization for services requiring such as :

- Home health care (See Section 5(a))
- Transplants (See Section 5(b))
- Hospice care (See Section 5(c))
- Skilled nursing facilities (See Section 5(c))
- Inpatient mental health and substance abuse treatment (See Section 5(e))
- Some prescription drugs (See Section 5(f))
- Facility admissions for Chemotherapy (See section 5(a))
- Facility admissions for Radiation (See section 5(a))
- Facility admissions for Dialysis (See section 5(a))
- Members seeking care with a Perinatologist

How to request precertification for an admission or get prior authorization for Other services

First, you, your representative, your physician, or your hospital must call us at 1-877-531-1159 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of planned days of confinement.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim.

If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an **urgent care claim** (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-877-531-1159. You may also call OPM's Health Insurance 2 at 202-606-3818 between 8 a.m. and 5 p.m. eastern time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, then call us at 1-877-531-1159. If it is determined that your claim is an urgent care claim, we will hasten our review (if we have not yet responded to your claim).

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital. If you do not telephone the Plan within two business days, penalties may apply - see *Warning* under *Inpatient hospital admissions* earlier in this Section and *If your hospital stay needs to be extended* below.

- **Maternity care**

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.

- **If your hospital stay needs to be extended**

If your hospital stay – including for maternity care – needs to be extended, you, your representative, your doctor or the hospital must ask us to approve the additional days. If you remain in the hospital beyond the number of days we approved and did not get the additional days precertified, then

 - For the part of the admission that was medically necessary, we will pay inpatient benefits, but
 - For the part of the admission that was not medically necessary, we will only pay for medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- If you disagree with our pre-service claim decision**

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accordance with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

 1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care, or grant your request for prior approval for a service, drug, or supply; or
 2. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

 3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your pre-service claim, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4, Your costs for covered services

This is what you will pay out-of-pocket for covered care.

Cost-sharing Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Copayments A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. You will only be responsible for one (1) copayment per day per provider.

Example: When you see your PPO physician you pay a copayment of \$15 per day, and when you go in a PPO hospital, you pay a copayment of \$200 per hospital stay.

Note: If the billed amount or the Plan allowance that providers we contract with have agreed to accept as payment in full is less than your copayment, you pay the lower amount.

Deductible A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible.

The *calendar* year deductible for PPO is \$350 per person and for non-PPO services it is \$400 per person. Under a family enrollment, the deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reaches \$700 for PPO and \$800 for non-PPO services.

If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount is \$100, the provider has an agreement with us to accept \$80, and you have not paid any amount toward meeting your deductible, you must pay \$80. We will apply \$80 to your deductible. We will begin paying benefits once the remaining portion of your calendar year deductible of \$350 for PPO or \$400 for non-PPO has been satisfied.

Note: If you change plans during Open Season and the effective date of your new plan is after January 1 of the next year, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Coinsurance Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.

Example: You pay 10% coinsurance of our allowance for an x-ray at a PPO provider.

If your provider routinely waives your cost Note: If your provider routinely waives (does not require you to pay) your copayments, deductibles, or coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

For example, if your physician ordinarily charges \$100 for a service but routinely waives your 10% coinsurance, the actual charge is \$90. We will pay \$81 (90% of the actual charge of \$90).

Waivers

In some instances, a provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the contracts that the Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at 1-877-531-1159.

Differences between our allowance and the bill

Our "Plan allowance" is the amount we use to calculate our payment for covered services. Fee-for-service plans arrive at their allowances in different ways, so their allowances vary. For more information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10.

Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the provider you use.

When you live in the Plan's PPO area, you should use a PPO provider. The following two examples explain how we will handle your bill when you go to a PPO provider and when you go to a non-PPO provider. When you use a PPO provider, the amount you pay is much less.

- **PPO providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example using coinsurance: You see a PPO physician who charges \$350, but our allowance is \$300. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just 10% of our \$300 allowance (\$30). Because of the agreement, your PPO physician will not bill you for the \$50 difference between our allowance and his/her bill.

Follow these steps when you use a PPO provider in order to receive PPO benefits:

- Verify with us that your address on record is in a PPO area;
 - When you call for an appointment, verify that the physician or facility is still a PPO provider and;
 - Present your PPO ID card confirming your PPO participation in order to receive PPO benefits.
- **Non-PPO providers**, on the other hand, have no agreement to limit what they will bill you. For instance,
- **When you reside in the PPO network area and use a non-PPO provider**, you will pay your deductible and coinsurance—plus any difference between our allowance and charges on the bill. Here is an example: You see a non-PPO physician who charges \$350 and our allowance is again \$300. Because you've met your deductible, you are responsible for your coinsurance, so you pay 30% of our \$300 allowance (\$90). Plus, because there is no agreement between the non-PPO physician and us, the physician can bill you for the \$50 difference between our allowance and his/her bill.

The following table illustrates the examples of how much you have to pay out-of-pocket for services from a PPO physician vs. a non-PPO physician when you reside in the PPO network area. The table uses our example of a service for which the physician charges \$350 and our allowance is \$300. The table shows the amount you pay if you have met your calendar year deductible.

EXAMPLE	PPO physician	Non-PPO physician
Physician's charge	\$350	\$350
Our allowance	We set it at: \$300	We set it at: \$300
We pay	90% of our allowance: \$270	70% of our allowance: \$210
You owe: Coinsurance	10% of our allowance: \$30	30% of our allowance: \$90
+Difference up to charge?	No: 0	Yes: \$50
TOTAL YOU PAY	\$30	\$140

Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

For those benefits where coinsurance or deductibles apply, we pay 100% of the Plan allowance for the rest of the calendar year after your expenses total:

- PPO providers: \$4,000—For you or any covered family member combined;
- Non-PPO providers: \$7,000—For you or any covered family member combined;

Out-of-pocket expenses are:

- Your \$350 self/\$700 self and family calendar year deductible for PPO and \$400 self/\$800 self and family for non-PPO;
- The percentage you pay for covered services after you have met your deductibles;
- The percentage you pay for surgery, anesthesia and extended medical care after an accidental injury; and
- Your copayment for hospital stays.

The following **cannot** be included in your out-of-pocket expenses:

- Expenses in excess of the Plan allowance or maximum benefit limitations;
- Non-covered services and supplies;
- Prescription drug copayments;
- Copayments, except for hospital admission copayments;
- Expenses for dental care including the \$100 copay you pay for dental care after an accidental injury; or
- Any amounts you pay if benefits have been reduced because of noncompliance with our precertification, prior authorization or prior approval requirements.

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error, but in good faith. We may reduce subsequent benefit payments to offset overpayments.

When Government facilities bill

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. High Option Benefits

See page 14 for how our benefits changed this year. Pages 90-92 are a benefits summary of our High Option.

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High Option Overview

This Plan offers a single benefit, with a two-tier reimbursement structure. Please refer to specific benefit sections of the brochure for information regarding reimbursement. Make sure that you review the benefits that are available under the Plan.

Highlights of this Plan include, but are not limited to:

- \$15 copayment for a physician per office visit
- \$25 copayment for a specialist per office visit
- No limit for annual routine physical exams, screenings and immunizations when you use a Preferred provider; the Plan will pay 100%.
- PPO benefit applies to providers used outside the 50 United States.
- Tobacco Cessation Program covered at 100%
- No referral required to see a specialist
- Extensive PPO network

To obtain claim forms, claims filling advice, or more information about the Plan, contact us at 1-866-368-7227 or go to our website www.compassrosebenefits.com.

See page 14 for how our benefits changed this year.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: \$350 per person for PPO and \$400 for non-PPO services (\$700 per family for PPO and \$800 for non-PPO services). The calendar year deductible applies to almost all benefits in this Section. We added ("No Deductible") to show when the calendar year deductible **does not** apply.
- PPO benefits apply only when you reside in the PPO network area and use a PPO provider or if a provider is used outside the 50 United States. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.

Benefit Description	You Pay
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	
Professional services of physicians (not including surgery) <ul style="list-style-type: none"> • In physician's office <ul style="list-style-type: none"> - office visits - consultations (to include second surgical opinion) - injections <p><i>Note: Drugs provided by the physician are covered under Section 5(f).</i></p> <p><i>Note: Supplies provided by the physician are covered under Section 5(a).</i></p>	PPO: \$15 copayment (No Deductible) \$25 copayment for Specialist (No Deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount \$15 copayment (No Deductible) \$25 copayment for Specialist (No Deductible) for providers used outside the 50 United States
Professional services of physicians (not including surgery) <ul style="list-style-type: none"> • In a hospital (Inpatient or Outpatient) • In an urgent care center • In a skilled nursing facility • At home 	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance for providers used outside the 50 United States
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms 	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance for providers used outside the 50 United States Nothing if LabCorp is used for Laboratory Services (No Deductible)

Benefit Description	You Pay
Lab, X-ray and other diagnostic tests (cont.)	
<ul style="list-style-type: none"> • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG • Sonograms 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>10% of the Plan allowance for providers used outside the 50 United States</p> <p>Nothing if LabCorp is used for Laboratory Services (No Deductible)</p> <p><i>Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and x-ray charges.</i></p>
Preventive care, adult	
<p>Routine physical examination per person to include a history and physical, chest x-ray, urinalysis, blood tests, and EKG (electrocardiogram).</p>	<p>PPO Services in physician's office: Nothing (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible)</p> <p>Nothing (No Deductible) for providers used outside the 50 United States</p>
<p>The following are paid in addition to the above benefit:</p> <ul style="list-style-type: none"> • One annual cervical cancer screening (Well woman) for women age 18 and older. <i>Note: if you see another physician for your Well woman, the office visit will be covered under Section 5(a) Diagnostic and treatment services.</i> • One annual Prostate Specific Antigen (PSA) test (prostate cancer screening) for men age 40 and older. • One annual fecal occult blood test (colorectal cancer screening) for members age 40 and older. • One routine sigmoidoscopy every five years starting at age 50. • One routine colonoscopy every ten years starting at age 50. • One annual routine mammogram (breast cancer screening) for women age 35 and older. • One annual fasting and one non-fasting blood cholesterol test every three consecutive calendar years. • Chlamydial screening. • One-time ultrasonography for abdominal aortic aneurysm screening, for males between the ages of 65 to 75 who have ever smoked. • Annual osteoporosis routine screening for members age 60 and older. • Human papillomavirus testing for women over 30 years of age and should occur no more frequently than every 3 years. • One annual counseling session for sexually transmitted infections for all sexually active women. 	<p>PPO: Nothing (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible)</p> <p>Nothing (No Deductible) for providers used outside the 50 United States</p>

Preventive care, adult - continued on next page

Benefit Description	You Pay
<p>Preventive care, adult (cont.)</p> <ul style="list-style-type: none"> • One annual counseling session for human immunodeficiency virus for all sexually active women. • One annual screening and counseling session for interpersonal and domestic violence. • Contraceptive methods and counseling. <p><i>Note: Your physician's bill must clearly state "Routine Physical Exam." If a medical diagnosis is provided on the bill, those services will be paid under the medical benefit.</i></p> <p><i>Note: We cover related services under the applicable benefits section (i.e., for facility charge, see Section 5(c)).</i></p>	<p>PPO: Nothing (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible)</p> <p>Nothing (No Deductible) for providers used outside the 50 United States</p>
<p>Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) :</p> <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster once every 10 years, ages 22 and over • Pneumococcal vaccine, annually • Influenza vaccine, annually • Varicella (Chickenpox) age 22 and older • Shingles Vaccine, age 50 and older • HPV, Adacel and Rotavirus vaccines 	<p>PPO: Nothing (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible)</p> <p>Nothing (No Deductible) for providers used outside the 50 United States</p>
<p>Preventive care, children</p>	
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics (to age 22) • Rotavirus vaccine for infants less than 1 year old • HPV, Adacel Vaccine and Rotavirus • Retinal Screening Exam performed by an ophthalmologist for infants with low birth weight less than 1 year of age and with an unstable clinical course. • Routine screening, testing, diagnosis and treatment (including hearing aids) for hearing loss. • Body Mass Index (BMI) Test for children ages 24 months to 22 years of age. 	<p>PPO: Nothing (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible)</p> <p>Nothing (No Deductible) for providers used outside the 50 United States</p>
<ul style="list-style-type: none"> • Well-child care charges for routine examinations and care (to age 22). • One annual routine physical examination (over age 2 to age 22). 	<p>PPO: Nothing (No Deductible)</p> <p>PPO: Services outside physician's office Nothing (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible)</p> <p>Nothing (No Deductible) for providers used outside the 50 United States</p>

Benefit Description	You Pay
<p>Maternity Care</p> <p>Complete maternity (obstetrical) care such as:</p> <ul style="list-style-type: none"> • Prenatal care (to include laboratory tests) • Amniocentesis • Delivery • Initial, routine examination of your newborn infant covered under your family enrollment • Postnatal care • One routine sonogram • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. <p>Note: Here are some things to keep in mind</p> <ul style="list-style-type: none"> • You do not have to precertify your normal delivery; see page 17 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary and precertified. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. If your baby stays in the hospital after your discharge and is covered under your Self and Family enrollment, you must precertify the extended stay and pay a separate hospital stay copayment. See Section 5(c). • Surgical benefits, not maternity benefits, apply to circumcision. • Bassinet or nursery charges on which you and your baby are confined are considered your maternity expenses, not your baby's. • Sonograms and other related tests that are not included in your routine prenatal or postnatal care are covered in Lab, x-ray, and other diagnostic tests, see pages 28-29. 	<p>PPO: 10% of the Plan allowance (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible)</p> <p>10% of the Plan allowance (No Deductible) for providers used outside the 50 United States</p>
<p>Breastfeeding support, supplies and counseling for each birth</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p> <p>Nothing (No deductible) for providers used outside the 50 United States</p>

Maternity Care - continued on next page

Benefit Description	You Pay
Maternity Care (cont.)	
<p><i>Not Covered:</i></p> <p><i>Routine sonograms to determine fetal age, size or sex; or procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.</i></p>	<p><i>All Charges</i></p>
Family Planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Section 5(b) for surgical procedures) • Surgically implanted contraceptives (See Section 5(b) for surgical procedures) • Fitting, inserting or removing intrauterine devices (such as diaphragms and IUDs) • Sterilization procedures, and patient education and counseling for all women with reproductive capacity • Injection of contraceptive drugs (such as Depo-Provera) 	<p>PPO: 10% of the Plan allowance (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p> <p>10% of the Plan allowance (No Deductible) for providers used outside of the 50 United States</p>
<ul style="list-style-type: none"> • Contraceptive counseling on an annual basis • All Food and Drug Administration approved generic contraceptive medications and devices <p><i>Note: FDA-approved prescription drugs and devices for birth control require a physician's prescription. Non-generic medications will be subject to the appropriate level 2 or level 3 prescription copay (See section 5(f) for prescription drug benefits). If there is no generic equivalent available, you pay nothing.</i></p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p> <p>Nothing (No deductible) for providers used outside the 50 United States</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization, genetic counseling.</i> 	<p><i>All charges</i></p>
Infertility services	
<p>Diagnosis and treatment of infertility except as shown in <i>Not covered</i>.</p> <ul style="list-style-type: none"> • Initial diagnostic tests and procedures done only to identify the cause of infertility • Fertility drugs, hormone therapy and related services • Medical or surgical procedures done to create or enhance fertility <p><i>Note: We will pay up to \$5,000 per person per live birth for covered infertility services, including prescription drugs.</i></p>	<p>PPO: 10% of the Plan allowance and charges in excess of \$5,000 per live birth</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and charges in excess of \$5,000 per live birth</p> <p>10% of the Plan allowance and charges in excess of \$5,000 per live birth for providers used outside of the 50 United States</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Infertility services after voluntary sterilization</i> 	<p><i>All charges</i></p>

Infertility services - continued on next page

Benefit Description	You Pay
Infertility services (cont.)	
<ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <i>Artificial insemination</i> <ul style="list-style-type: none"> - <i>Invitro fertilization</i> - <i>Embryo transfer and gamete intrafallopian transfer (GIFT)</i> - <i>Intravaginal insemination (IVI)</i> - <i>Intracervical insemination (ICI)</i> - <i>Intrauterine insemination (IUI)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<i>All charges</i>
Allergy care	
<p>Allergy testing, injections and treatment (including allergy serum).</p>	<p>PPO services in physician's office: \$15 copayment (No Deductible) \$25 copayment for Specialist (No Deductible)</p> <p>PPO services outside physician's office: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>\$15 copayment (No Deductible) \$25 copayment for Specialist (No Deductible) for providers used outside the 50 United States</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>RAST tests</i> • <i>Food tests</i> • <i>End Point titration techniques</i> • <i>Sublingual allergy desensitization</i> • <i>Hair analysis</i> 	<i>All charges</i>
Treatment therapies	
<p>Chemotherapy and radiation therapy (high dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed in Section 5(b) <i>Organ/tissue transplants.</i>)</p> <ul style="list-style-type: none"> • Renal Dialysis • Intravenous (IV)/Infusion Therapy Home IV and antibiotic therapy 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>10% of the Plan allowance for providers used outside the 50 United States</p>

Treatment therapies - continued on next page

Benefit Description	You Pay
Treatment therapies (cont.)	
<ul style="list-style-type: none"> • Respiratory and inhalation therapies • Growth hormone therapy (GHT). <p>We only cover GHT when you obtain prior approval. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services that we determine are medically necessary. See Other services under You need prior Plan approval for certain services on page 17.</p> <p>Note: We cover drugs administered for therapies listed above in Section 5(f).</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>10% of the Plan allowance for providers used outside the 50 United States</p>
Physical, occupational, and speech therapies	
<p>90 total combined outpatient physical, speech and occupational therapy visits per calendar year for the following:</p> <p>Visits for the services of each of the following:</p> <ul style="list-style-type: none"> • Physicians • Qualified physical therapists • Speech therapists • Occupational therapists <p><i>Note: 90 total combined visits does not include inpatient physical, speech and occupational therapy, which is covered under Section 5(c) hospital or facility coverage.</i></p> <p>Note: Therapy may not be rendered by a chiropractor.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>10% of the Plan allowance for providers used outside the 50 United States</p>
<p><i>Note: We only cover therapy when a physician:</i></p> <ul style="list-style-type: none"> • orders the care; • identifies the specific professional skills you require and the medical necessity for skilled services; and • indicates the length of time you need the services. <p><i>Note: We only cover physical and occupational therapy to restore bodily function when there has been a total or partial loss due to illness or injury.</i></p> <p><i>Note: Inpatient rehabilitative services are covered under Section 5(c)</i></p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs 	<p><i>All charges</i></p>

Benefit Description	You Pay
Hearing services (testing, treatment, and supplies)	
<p>Routine Hearing Exam</p> <p>For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist</p> <p>Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) <i>Preventive care, children</i>.</p>	<p>Nothing (No deductible) for PPO, non-PPO and for providers used outside the 50 United States</p>
<p>Hearing aids for adults - one hearing aid and related services per ear every five calendar years.</p> <ul style="list-style-type: none"> • External hearing aids <p>Note: For benefits on these devices, see Section 5(a) <i>Orthopedic and prosthetic devices</i>.</p>	<p>PPO, non-PPO and providers used outside the 50 United States: All charges over \$1,200 for one hearing aid per ear, every five calendar years.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Hearing services that are not shown as covered</i> 	<p><i>All charges</i></p>
Vision services (testing, treatment, and supplies)	
<p>One (1) pair of eyeglasses with standard frames or one (1) pair of contact lenses per incident to correct an impairment directly caused by:</p> <ul style="list-style-type: none"> • Accidental ocular injury or • Surgery in connection with the following diagnosis specifically ordered by the physician: <ul style="list-style-type: none"> • Cataract • Keratoconus or • Glaucoma <p><i>Note: Services must be received within one year of the date of accident or surgery.</i></p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>10% of the Plan allowance for providers used outside the 50 United States</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses and examinations for them, except for accidental injury and intraocular surgery</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> • <i>Eye refractions</i> 	<p><i>All charges</i></p>
Foot care	
<p><i>Not Covered:</i></p> <p><i>We do not provide benefits for routine foot care, such as:</i></p> <ul style="list-style-type: none"> • <i>Treatment or removal of corns and calluses, or trimming of toenails</i> • <i>Orthopedic shoes, orthotics and other supportive devices for the feet</i> 	<p><i>All charges</i></p>

Benefit Description	You Pay
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> •Artificial limbs and eyes; •Stump hose •Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy •Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. •Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implants following mastectomy. <p><i>Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.</i></p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>10% of the Plan allowance for providers used outside the 50 United States</p>
<p>Diabetic shoes</p> <p>One pair of diabetic shoes per person. Replacements allowed annually</p>	<p>PPO, Non-PPO and providers used outside the 50 United States: All charges in excess of \$150 (No deductible)</p>
<p>Wigs up to \$300 while covered under this Plan, when required due to hair loss in connection with chemotherapy or radiation treatment</p>	<p>PPO, Non-PPO and providers used outside the 50 United States: All charges in excess of \$300 for 1 wig</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> •Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups •Lumbosacral supports •Corsets, trusses, elastic stockings, support hose, and other supportive devices 	<p><i>All charges</i></p>
Durable medical equipment (DME)	
<p>Durable medical equipment (DME) is equipment and supplies that:</p> <ol style="list-style-type: none"> 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. <p>We cover purchase or rental up to the purchase price, at our option, including repair and adjustment, of durable medical equipment. Under this benefit, we also cover:</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>10% of the Plan allowance for providers used outside the 50 United States</p>

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay
Durable medical equipment (DME) (cont.)	
<ul style="list-style-type: none"> • Oxygen; • Hospital beds; • Dialysis equipment; • Glucose Monitors; • Respirators; • Wheelchairs, crutches, canes, walkers, casts; • Cervical collars and traction kits; and • Splints 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>10% of the Plan allowance for providers used outside the 50 United States</p>
<p>We cover the rental or purchase of augmentative and alternative communication devices such as:</p> <ul style="list-style-type: none"> • Computer story boards • Light talkers • Enhanced vision systems • Speech aid prosthesis for pediatrics • Speech aid prosthesis for adults 	<p>PPO, Non-PPO and providers used outside the 50 United States :</p> <p>All charges in excess of \$1200 for 1 device. Replacements allowed every 3 years</p>
<p><i>Not covered:</i></p> <p><i>Sun or heat lamps, whirlpool baths, heating pads, air purifiers, humidifiers, air conditioners, and exercise devices</i></p>	<p><i>All charges</i></p>
Home health services	
<p>For services provided on a part-time basis (less than an 8-hour shift):</p> <p>If precertified, 90 visits per calendar year up to a maximum Plan payment of \$180 per visit when:</p> <ul style="list-style-type: none"> • A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services; • The attending physician orders the care; • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and • The physician indicates the length of time the services are needed. <p>If not precertified, 40 visits per calendar year up to a maximum plan payment of \$40, subject to the above provisions.</p> <p><i>Note: Precertified and Nonprecertified visits are combined. Visit limit not to exceed 90 visits per calendar year.</i></p> <p><i>Note: All therapy services will count toward the 90-day therapy visit limitation per calendar year, as listed under Physical, occupation and speech therapy in Section 5(a).</i></p>	<p>PPO: Charges in excess of \$180 per visit (No Deductible) (90 visit maximum). All charges over the visit limit.</p> <p>Non-PPO: Charges in excess of \$180 per visit and any difference between the Plan allowance and the billed amount (No Deductible) (90 visit maximum). All charges over the visit limit.</p> <p>Charges in excess of \$180 per visit (No Deductible) (90 visit maximum). All charges over the visit limit for providers used outside the 50 United States</p> <p>If not precertified, 40 visits per calendar year up to a maximum plan payment of \$40, subject to the above provisions.</p>
<p>For private duty nursing provided on a full-time basis (more than an 8-hour shift) by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) when:</p>	<p>PPO: 10% of the Plan allowance</p>

Home health services - continued on next page

Benefit Description	You Pay
Home health services (cont.)	
<ul style="list-style-type: none"> the care is ordered by the attending physician, and your physician identifies the specific professional nursing skills that you require, as well as the length of time needed. 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>10% of the Plan allowance for providers used outside the 50 United States</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Nursing care requested by, or for the convenience of, the patient or the patient's family; Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, rehabilitative; Custodial care as defined in Section 10. 	<p><i>All charges</i></p>
Chiropractic	
<p>Covered services are limited to:</p> <ul style="list-style-type: none"> Manipulation of the spine and extremities <p><i>Note: Chiropractic is a system of therapy that attributes disease to abnormal function of the nervous system and attempts to restore normal function by manipulation of the spinal column and other body structures.</i></p>	<p>PPO: \$20 copayment (No Deductible) up to the Plan maximum of 20 visits per person per calendar year</p> <p>Non-PPO: 30% of the Plan Allowance and any difference between our allowance and the billed amount up to the Plan maximum of 20 visits per person per calendar year</p> <p>\$20 copayment (No Deductible) up to the Plan maximum of 20 visits per person per calendar year for providers used outside the 50 United States</p>
Alternative treatments	
<p>Acupuncture when used as an anesthetic agent for covered surgery</p>	<p>PPO: 10% of the Plan allowance (No Deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible)</p> <p>10% of the Plan allowance (No Deductible) for providers used outside the 50 United States</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Chelation therapy except for acute arsenic, gold, mercury, lead, or use of Deferoxamine in iron poisoning Naturopathic services Homeopathic services and medicines <p><i>Note: Benefits of certain alternative treatment providers may be covered in medically underserved areas.</i></p>	<p><i>All charges</i></p>

Benefit Description	You Pay
Educational classes and programs	
<p>Nutritional therapy</p> <p>Coverage Limited to:</p> <ul style="list-style-type: none"> Nutritional counseling <p><i>Note: We cover dieticians, nutritionists and diabetic educators who bill independently for nutritional counseling.</i></p>	<p>PPO, Non-PPO and providers used outside the 50 United States: All charges in excess to 4 nutritional counseling sessions per year</p>
<p>Diabetes training</p> <p><i>Note: Prescription drugs are covered under section 5(f).</i></p>	<p>PPO: \$15 copayment (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible)</p> <p>\$15 copayment (No Deductible) for providers used outside the 50 United States</p>
<p>Tobacco Cessation</p> <p>Programs including individual/group/telephone counseling, physician written and prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. Coverage is provided for:</p> <ul style="list-style-type: none"> Tobacco Cessation Benefits Program for members will be provided for up to four smoking cessation counseling sessions per quit attempt and two quit attempts per year. Prescription and over the-counter drugs for Tobacco cessation for members. <p><i>Note: All prescriptions, including over the counter medications require a written prescription from your physician.</i></p>	<p>PPO, Non-PPO and providers used outside the 50 United States: Nothing (No Deductible)</p> <p>Nothing for physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence.</p>

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible does not apply for these benefits; however, we added —“(No Deductible)” - to show that the calendar year deductible does not apply. See Section 5(a).
- PPO benefits apply only when you reside in the PPO network area and use a PPO provider. When no PPO provider is available, non-PPO benefits apply. If outside the 50 United States the PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- The amounts listed below are for the charges billed by a physician or other health care professionals for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).

YOU MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You Pay After the calendar year deductible...
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) 	<p>PPO: 10% of the Plan allowance (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p> <p>10% of the Plan allowance (No Deductible) for providers used outside the 50 United States</p>
<p>• Surgical treatment of morbid obesity (bariatric surgery) – a condition in which an individual (1) is the greater of 100 pounds or 100% over his/her normal weight (in accordance with our underwriting standards) with complicating conditions; (2) has been so for at least five years with documented unsuccessful attempts to reduce under a doctor-monitored diet and exercise program and; (3) is age 18 or older.</p> <p><i>Note: The procedure must be performed at a UnitedHealthcare Bariatric Centers of Excellence to receive PPO level of benefits.</i></p>	<p>PPO: 10% of the Plan allowance (No Deductible) when a UnitedHealthcare Bariatric Centers of Excellence is used</p> <p>Non-PPO: 100%</p> <p>10% of the Plan allowance (No Deductible) for providers used outside the 50 United States</p>
<ul style="list-style-type: none"> • Insertion of internal prosthetic devices. See Section 5(a) for device coverage information. • Voluntary sterilization (e.g., tubal ligation, vasectomy) 	<p>PPO: 10% of the Plan allowance (No Deductible)</p>

Surgical procedures - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Surgical procedures (cont.)	
<ul style="list-style-type: none"> • Surgically implanted contraceptives, and intrauterine devices (IUDs) • Treatment of burns • Surgical treatment of bunions or spurs • Assistant surgeons - we cover up to 20% of our allowance for the surgeon's charge <p><i>Note: For related services, see applicable benefits section (i.e., for inpatient hospital benefits, see Section 5(c)).</i></p>	<p>PPO: 10% of the Plan allowance (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p> <p>10% of the Plan allowance (No Deductible) for providers used outside the 50 United States</p>
<p>When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are:</p> <p>For the primary procedure:</p> <ul style="list-style-type: none"> • PPO: 90% of the Plan allowance (No Deductible) • Non-PPO: 70% of the Plan allowance (calendar year deductible applies) <p>For the secondary procedure(s):</p> <ul style="list-style-type: none"> • PPO: 90% of one-half of the Plan allowance (No Deductible) • Non-PPO: 70% of one-half of the Plan allowance (calendar year deductible applies) <p><i>Note: Multiple or bilateral surgical procedures performed through the same incision are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.</i></p>	<p>PPO: 10% of the Plan allowance for the primary procedure and 10% of one-half of the Plan allowance for the secondary procedure(s) (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance for the primary procedure and 30% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our payment and the billed amount (calendar year deductible applies)</p> <p>10% of the Plan allowance for the primary procedure and 10% of one-half of the Plan allowance for the secondary procedure(s) (No Deductible) for providers used outside the 50 United States</p> <p><i>Note: For certain surgical procedures, we may apply a value of less than 50% of subsequent procedures.</i></p>
<p><i>Not covered:</i></p> <p><i>Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standbys are medically necessary.</i></p>	<p><i>All charges</i></p>
Reconstructive surgery	
<p>Surgery to correct a functional defect</p> <p>Surgery to correct a condition caused by injury or illness if:</p> <ul style="list-style-type: none"> • the condition produced a major effect on the member's appearance and; • the condition can reasonably be expected to be corrected by such surgery. <p>Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of the congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes.</p>	<p>PPO: 10% of the Plan allowance (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p> <p>10% of the Plan allowance (No Deductible) for providers used outside the 50 United States</p>
<p>All stages of breast reconstruction surgery following a mastectomy, such as:</p>	<p>PPO: 10% of the Plan allowance (No Deductible)</p>

Reconstructive surgery - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Reconstructive surgery (cont.)	
<ul style="list-style-type: none"> • surgery to produce a symmetrical appearance of breasts • treatment of any physical complications, such as lymphedemas • breast prostheses; and surgical bras and replacements (see Prosthetic devices for coverage) <p><i>Note: Internal breast prostheses are covered under Section 5(a).</i></p> <p><i>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</i></p>	<p>PPO: 10% of the Plan allowance (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed (calendar year deductible applies)</p> <p>10% of the Plan allowance (No Deductible) for providers used outside the 50 United States</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation or sexual dysfunction</i> 	<p><i>All charges</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Surgical correction of temporomandibular joint (TMJ) dysfunction • Surgical removal of impacted teeth, including anesthesia charges • Other surgical procedures that do not involve the teeth or their supporting structures 	<p>PPO: 10% of the Plan allowance (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p> <p>10% of the Plan allowance (No Deductible) for providers used outside the 50 United States</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants, transplants and related services</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> • <i>Pre- and post-operative examinations in preparation for surgical removal of impacted teeth</i> 	<p><i>All charges</i></p>

Benefit Description	You Pay After the calendar year deductible...
<p>Organ/tissue transplants</p> <p>These solid organ transplants are covered.</p> <p>Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver- Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung single/bilateral/lobar • Pancreas • Autologous islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis 	<p>PPO: 10% of the Plan allowance (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p> <p>10% of the Plan allowance (No Deductible) for providers used outside the 50 United States</p>
<p>These tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan. Refer to <i>Other services</i> in Section 3 for prior authorization procedures.</p> <ul style="list-style-type: none"> • Autologous tandem transplants for: <ul style="list-style-type: none"> - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) 	<p>PPO: 10% of the Plan allowance (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p> <p>10% of the Plan allowance (No Deductible) for providers used outside the 50 United States</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis 	<p>PPO: 10% of the Plan allowance (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p> <p>10% of the Plan allowance (No Deductible) for providers used outside the 50 United States</p>

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible...
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia <p>• Autologous transplants for:</p> <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Epithelial ovarian cancer - Medulloblastoma - Multiple myeloma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors 	<p>PPO: 10% of the Plan allowance (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p> <p>10% of the Plan allowance (No Deductible) for providers used outside the 50 United States</p>
<p>Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan.</p> <p>Refer to <i>Other services</i> in Section 3 for prior authorization procedures:</p> <p>Allogeneic transplants for</p> <ul style="list-style-type: none"> • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Amyloidosis 	<p>PPO: 10% of the Plan allowance (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p> <p>10% of the Plan allowance (No Deductible) for providers used outside the 50 United States</p>

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible...
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Severe combined immunodeficiency • Severe or very severe aplastic anemia <p>Autologous transplants for:</p> <ul style="list-style-type: none"> • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Advanced Neuroblastoma • Medulloblastoma 	<p>PPO: 10% of the Plan allowance (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p> <p>10% of the Plan allowance (No Deductible) for providers used outside the 50 United States</p>
<p><i>Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.</i></p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except as shown above • Implants of artificial organs • Transplants not listed as covered 	<p><i>All charges</i></p>
<p><i>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</i></p> <p><i>Note: All allowable charges incurred for a surgical transplant, whether incurred by the recipient or donor will be considered expenses of the recipient and will be covered the same as for any other illness or injury subject to the limits stated below. This benefit applies only if we cover the recipient and if the donor's expenses are not otherwise covered.</i></p> <p><i>Note: We cover donor screening testing for up to four potential bone marrow transplant donors per year from individuals unrelated to the patient, in addition to testing of family members.</i></p>	<p>PPO: 10% of the Plan allowance (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p> <p>10% of the Plan allowance (No Deductible) for providers is used outside the 50 United States(No Deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Services or supplies for or related to surgical transplant procedures (including administration of high-dose chemotherapy) for artificial or human organ/tissue transplants not listed as specifically covered. 	<p><i>All charges</i></p>

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Donor search expense for bone marrow transplants 	All charges
<p>Limited Benefits:</p> <ul style="list-style-type: none"> • The process for preauthorizing organ transplants is more extensive than the normal precertification process. Before your initial evaluation as a potential candidate for a transplant procedure, you or your doctor must contact the Plan's Medical Management Program so we can arrange to review the clinical results of the evaluation and determine if the proposed procedure meets our definition of "medically necessary" and is on the list of covered transplants. Coverage for the transplant must be authorized in advance, in writing by the Plan's Medical Management Program. • We will pay for a second transplant evaluation recommended by a physician qualified to perform the transplant, if the transplant diagnosis is covered and the physician is not associated or in practice with the physician who recommended and will perform the organ transplant. A third transplant evaluation is covered only if the second evaluation does not confirm the initial evaluation. • The transplant must be performed at a CoFinity Transplant Center of Excellence to receive maximum benefits. • If benefits are limited to \$100,000 per transplant, included in the maximum are all charges for hospital, medical and surgical care incurred while the patient was hospitalized for a covered transplant surgery and subsequent complications related to the transplant. Outpatient expenses for chemotherapy and any process of obtaining stem cells or bone marrow associated with bone marrow transplant (stem cell support) are included in benefits limit of \$100,000 per transplant. Tandem bone marrow transplants approved as one (1) treatment protocol are limited to \$100,000 when not performed at a CoFinity Transplant Center of Excellence. Expenses for aftercare such as outpatient prescription drugs are not a part of the \$100,000 limit. • Chemotherapy and procedures related to bone marrow transplantation must be performed only at a CoFinity Transplant Center of Excellence to receive maximum benefits. • Simultaneous transplants such as kidney/pancreas, heart/lung, heart/liver are consider as one transplant procedure and are limited to \$100,000 when not performed at a CoFinity Transplant Center of Excellence. 	<p>PPO: 10% of the Plan allowance (No Deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p> <p>10% of the Plan allowance (No Deductible) for providers used outside the 50 United States</p> <p><i>Note: If prior approval is not obtained or a CoFinity Transplant Center of Excellence is not used, our allowance will be limited for hospital and surgery expenses up to a maximum of \$100,000 per transplant. If we cannot refer a member in need of a transplant to a designated facility, the \$100,000 maximum will not apply.</i></p>
Transportation Benefit	

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> • We will also provide up to \$10,000 per covered transplant for transportation (mileage or airfare) to a Co-Finity Transplant Center of Excellence and reasonable temporary living expenses (i.e., lodging and meals) for the recipient and one other individual (or in the case of a minor, two other individuals), if the recipient lives more than 100 miles from the designated transplant facility. • Transportation benefits are payable for follow-up care up to one year following the transplant. You must contact Customer Service for what are considered reasonable temporary living expenses. 	
Anesthesia	
<p>Professional services provided in:</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>PPO: 10% of the Plan allowance (No Deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p> <p>10% of the Plan allowance (No Deductible) for providers used outside the 50 United States</p>

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. We added (calendar year deductible applies). The calendar year deductible is: \$350 per person (\$700 per family) for PPO and \$400 per person (\$800 per family) for non-PPO services. The non-PPO benefits are the standard benefits of this Plan.
- PPO benefits apply only when you reside in the PPO network area and use a PPO provider. When no PPO provider is available, non-PPO benefits apply. PPO benefits apply when you reside outside the 50 United States.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM \$500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

TO OBTAIN THE MAXIMUM BENEFITS, YOU SHOULD GET PRECERTIFICATION OF CARE YOU RECEIVE IN SKILLED NURSING FACILITIES, HOSPICE, AND ALSO HOME HEALTH CARE. Please refer to this section (Skilled nursing facility benefits and Hospice care) and Section 5(a) *Home health services* for details on how your benefits are affected if you do not certify. Also, please refer to Section 3 for additional details on precertification.

Benefit Description	You Pay
Note: The calendar year deductible applies ONLY when we say below: “(calendar year deductible applies)”.	
Inpatient hospital	
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate or intensive care accommodations; • General nursing care; • Meals and special diets. • Operating, recovery, and other treatment rooms • Rehabilitative services • Prescribed drugs and medicines • Diagnostic laboratory tests and x-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics 	PPO: \$200 copayment per hospital stay Non-PPO: \$400 copayment per hospital stay and 30% of the Plan allowance and any difference between the Plan allowance and the billed amount \$200 copayment per hospital stay for providers used outside the 50 United States

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	
<p><i>Note: Take-home drugs are covered under Section 5(f).</i></p> <p><i>Note: Medical supplies, medical equipment, prosthetic and orthopedic devices and any covered items billed by a hospital for use at home are covered under Section 5(a) and the calendar year deductible and coinsurance apply.</i></p>	<p>PPO: \$200 copayment per hospital stay</p> <p>Non-PPO: \$400 copayment per hospital stay and 30% of the Plan allowance and any difference between the Plan allowance and the billed amount</p> <p>\$200 copayment per hospital stay for providers used outside the 50 United States</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Any part of a hospital admission that is not medically necessary (see definition in Section 10) such as when you do not need the acute hospital inpatient (overnight) setting but could receive care in some other setting without adversely affecting your condition or the quality of the medical care. <i>Note: In this event, we pay benefits for services and supplies, excluding room and board and inpatient physician care, at the level of benefits that would have been covered if provided in another approved setting.</i> • Inpatient hospital services and supplies for surgery that we do not cover • Custodial care (see definition, Section 10) even when provided by a hospital • Non-covered facilities, such as nursing homes, rest homes, places for the aged, convalescent homes or any place that is not a hospital, skilled nursing facility, or hospice • Personal comfort items, such as radio, television, telephone, beauty and barber services • Private nursing care • Long term rehabilitative therapy 	<p><i>All charges</i></p>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines for use in the facility • X-ray, laboratory and pathology services, and machine diagnostic tests • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Outpatient facility room charges 	<p>PPO: 10% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between the plan allowance and the billed amount (calendar year deductible applies)</p> <p>10% of the Plan allowance (calendar year deductible applies) for providers used outside the 50 United States</p>
<p><i>Note: Take-home drugs are covered under Section 5(f).</i></p>	

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You Pay
Outpatient hospital or ambulatory surgical center (cont.)	
<p><i>Note: Medical supplies, medical equipment, prosthetic and orthopedic devices and any covered items billed by a hospital for use at home are covered under Section 5(a) and the calendar year deductible and coinsurance apply.</i></p> <p><i>Note: We cover hospital services related to dental procedures (even though the dental procedure itself may not be covered) only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard your health.</i></p>	
Skilled nursing care facility benefits	
<p>If precertified, we cover semiprivate room, board, services and supplies in a Skilled Nursing Facility (SNF) for up to 90 days when:</p> <ol style="list-style-type: none"> 1. Skilled Nursing Facility stay is medically necessary and; 2. when the Skilled Nursing Facility is under the supervision of a physician. 	<p>PPO: Charges in excess of 90-day maximum</p> <p>Non-PPO: Charges in excess of 90-day maximum and any difference between our allowance and the billed amount</p> <p>Charges in excess of 90-day maximum for providers used outside the 50 United States</p>
<p>If not precertified, we cover semiprivate room, board, services and supplies for up to 45 days subject to the above conditions</p> <p><i>Note: Precertified and non-precertified days are combined. Day limit not to exceed 90 days per calendar year.</i></p>	<p>PPO: 20% of the Plan allowance and any charges in excess of the 45-day maximum</p> <p>Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount for 45 days, then all additional charges</p> <p>20% of the Plan allowance and any changes in excess of the 45-day maximum for providers used outside the 50 United States</p>
<i>Not Covered: Custodial care</i>	<i>All charges</i>
Hospice care	
<p>Hospice is a coordinated inpatient and outpatient program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan approved independent hospice administration.</p>	<p>PPO, Non-PPO and providers used outside the 50 United States: 14 inpatient day limit, unlimited outpatient days</p>
Ambulance	
<ul style="list-style-type: none"> • Professional ambulance service (including air ambulance when medically necessary) to or from the nearest hospital equipped to handle your condition. • Transportation by professional ambulance, railroad or commercial air line on a regularly scheduled flight to the nearest hospital equipped to furnish special and unique treatment when medically appropriate. 	<p>10% of the Plan allowance (calendar year deductible applies)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Ambulance transportation from hospital to home</i> • <i>Ambulance transport for you or your family's convenience</i> 	<i>All charges</i>

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: \$350 per person (\$700 per family) for PPO and \$400 per person (\$800 per family) for non-PPO services. The calendar year deductible applies to almost all benefits in this Section. We added - (No Deductible) - to show when the calendar year deductible does not apply.
- PPO benefits apply only when you reside in the PPO network area and use a PPO provider or if you use a provider outside the 50 United States. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.

What is an accidental injury?

An accidental injury is a bodily injury that requires immediate medical attention and is sustained solely through violent, external, and accidental means, such as broken bones, animal bites, insect bites and stings, and poisonings. Accidental dental injury is covered under Section 5(g).

Benefit Description	You pay After the calendar year deductible...
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Accidental injury	
<p>We pay 100% of the Plan allowance after the listed copays for the following care you receive as a result of an accidental injury:</p> <ul style="list-style-type: none"> • Emergency room (ER) facility charge and ER physician's charge or • Initial office visit for accidental injury <p><i>Note: We pay for services performed outside the ER facility under the appropriate Plan benefit.</i></p> <p><i>Note: We pay for services in the ER, but billed separately from the hospital bill such as x-ray, laboratory, pathology and machine diagnostic tests under the appropriate Plan benefit (see Section 5 (a)).</i></p> <p><i>Note: We pay Hospital benefits as specified in Section 5(c) if you are admitted to the hospital.</i></p> <p><i>Note: We pay for services performed at the time of the initial office visit such as x-ray, laboratory tests, drugs or any supplies or other services under the appropriate Plan benefit (see Section 5 (a)).</i></p>	<p>PPO services in physician's office: Nothing (No Deductible)</p> <p>PPO services outside physician's office: \$100 copay per occurrence (No Deductible) (copay is waived if admitted to the hospital)</p> <p>Non-PPO service in physician's office: Nothing (No Deductible)</p> <p>Non-PPO Services outside physician's office: \$100 copay per occurrence (No Deductible) (copay is waived if admitted to the hospital)</p> <p>Services in physician's office: Nothing for providers used outside the 50 United States</p> <p>Services outside physician's office: \$100 copay per occurrence (No Deductible) (copay is waived if admitted to the hospital) for services used outside the 50 United States</p>
<p>If you receive outpatient care for your accidental injury in an urgent care center, we cover:</p> <ul style="list-style-type: none"> • Non-surgical physician services and supplies • Surgery and related services 	<p>PPO services in the physician's office: \$50 copay (No Deductible)</p> <p>PPO service outside physician's office: \$50 copay per occurrence (No Deductible) (copay is waived if admitted to the hospital)</p>

Accidental injury - continued on next page

Benefit Description	You pay After the calendar year deductible...
Accidental injury (cont.)	
	<p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p> <p>\$50 copay per occurrence for providers used outside of the 50 United States (No Deductible) Copay is waived if admitted to the hospital.</p>
Medical emergency	
<p>Regular Plan benefits apply except for the copays listed on the right when you receive care because of a non-accidental medical emergency. See Section 5(a).</p>	<p>PPO services in physician's office: \$15 copayment (No Deductible) \$25 copayment for Specialist (No Deductible)</p> <p>PPO services outside physician's office: \$100 copay per occurrence and 10% of the Plan allowance (copay is waived if admitted to the hospital). No Deductible</p> <p>Non-PPO: \$100 copay per occurrence and 10% of Plan allowance (copay is waived if admitted to the hospital) (No Deductible)</p> <p>Services in physician's office: \$15 copayment (No Deductible) \$25 copayment for Specialist (No Deductible)r providers used outside the 50 United States</p> <p>Services outside physician's office: \$100 copay per occurrence for providers used outside the 50 United States. (No Deductible)</p>
<p>If you receive outpatient care for your medical emergency in an urgent care center, we cover:</p> <ul style="list-style-type: none"> • Non-Surgical physician services and supplies • Surgery and related services 	<p>PPO services in physician's office: \$50 copay (No Deductible)</p> <p>PPO service outside physican's office: \$50 copay per occurrence (No Deductible) (copay is waived if admitted to the hospital)</p> <p>Non-PPO: 30% of Plan allowance and the billed amount (No Deductible)</p> <p>\$50 copay per occurrence for providers used outside the 50 United States (No Deductible) Copay is waived if admitted to the hospital</p>
Ambulance	
<ul style="list-style-type: none"> • Professional ambulance service (including air ambulance when medically necessary) to or from the nearest hospital equipped to handle your condition. • Transportation by professional ambulance, railroad or commercial air line on a regularly scheduled flight to the nearest hospital equipped to furnish special and unique treatment when medically appropriate. 	<p>10% of Plan allowance</p>

Ambulance - continued on next page

Benefit Description	You pay After the calendar year deductible...
Ambulance (cont.)	
Not covered: <ul style="list-style-type: none"> • <i>Ambulance transportation from hospital to home</i> • <i>Ambulance transport for you or your family's convenience</i> 	<i>All charges</i>

Section 5(e). Mental health and substance abuse benefits

If you reside in the PPO Network Area, you may choose to get PPO or non-PPO care. Cost-sharing and limitations for PPO mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions. If you use a provider outside the 50 United States the PPO benefit applies.

Important things you should keep in mind about these benefits:

- Please remember all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.

We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.

OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one (1) clinically appropriate treatment plan in favor of another.

Benefit Description	You Pay After the calendar year deductible...
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>	
Professional Services	
<p>We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.</p>	<p>Your cost-sharing responsibilities are no greater than for other illnesses or conditions.</p>
<p>Professional Services Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:</p> <ul style="list-style-type: none"> • Diagnosis evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy 	<p>PPO services in physician's office: \$15 copayment (No Deductible)</p> <p>PPO services outside physician's office: 10% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>PPO services in physician's office: \$15 copayment (No Deductible) for providers used outside the 50 United States.</p> <p>PPO services outside physician's office: 10% of the Plan allowance and any difference between our allowance and the billed amount for providers used outside the 50 United States</p>
<p>Diagnostics</p> <ul style="list-style-type: none"> • Outpatient diagnostic tests are provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>10% of the Plan allowance for providers used outside the 50 United States</p>

Benefit Description	You Pay After the calendar year deductible...
Professional Services (cont.)	
<p>Inpatient hospital and other covered facility Inpatient services provided and billed by a hospital or other covered facility</p> <ul style="list-style-type: none"> • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Inpatient diagnostic tests provided and billed by a hospital or other covered facility 	<p>PPO: \$200 copayment per hospital stay Non-PPO: \$400 copayment per hospital stay and 30% of the Plan allowance and any difference between our allowance and the billed amount.</p> <p>\$200 copayment per hospital stay for providers used outside the 50 United States</p>
<p>Outpatient hospital or other covered facility Outpatient services provided and billed by a hospital or other covered facility</p> <ul style="list-style-type: none"> • Services such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment 	<p>PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount 10% of the Plan allowance for providers used outside the 50 United States</p>
<p><i>NOTE: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one (1) clinically appropriate treatment plan in favor of another.</i> <i>Not covered under mental health and substance abuse:</i></p> <ul style="list-style-type: none"> • <i>Services we have not approved</i> • <i>All charges for chemical aversion therapy, conditioned reflex treatments, narcotherapy or any similar aversion treatments and all related charges (including room and board)</i> • <i>Any provider not specifically listed as covered</i> 	<p><i>You pay all charges</i></p>

See these sections of the brochure for more valuable information about these benefits:

- Section 4, *Your cost for covered services*, for information about catastrophic protection for these benefits
- Section 7, *Filing a claim for covered services*, for information about submitting non-PPO claims

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described below.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Certain drugs require prior authorization or may be subject to quantity limits. If your prescription is for a drug requiring prior authorization, additional information from your physician will be needed before the medication is dispensed. Your physician may call 1-877-531-1159 to begin the review process.
- The calendar year deductible does not apply to almost all benefits in this Section. We added - (No Deductible) - to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.

There are important features you should be aware of. These include:

Who can write your prescription. A licensed physician or dentist must write the prescription.

Where you can obtain them. You may fill the prescription at a network pharmacy or by mail. To locate a network pharmacy in your area, call 1-877-438-4449 or visit Express Scripts website at www.express-scripts.com/pharmacy. We will send you information on the mail order drug program. To use the program: 1) complete the initial mail order form; 2) enclose your prescription and copayment; 3) mail your order to Express Scripts, PO Box 30117 Tampa, FL 33630-3117 ; 4) allow two to three weeks for delivery. You will receive forms for refills and future prescription orders each time you receive drugs or supplies under this program. If you have questions about the mail order program, call 1-877-438-4449.

We use a formulary. A formulary is a list of selected FDA-approved commonly prescribed medications from which your physician or dentist may choose to prescribe. The formulary is designed to inform you and your physician about quality medications that, when prescribed in place of other nonformulary medications, can help contain the increasing cost of prescription drug coverage without sacrificing quality. To find out if your medication is on the formulary, call Express Scripts, at 1-877-438-4449 or visit Compass Rose's website at www.compassrosebenefits.com/formulary. If you are prescribed a drug not on the formulary, you will pay a higher copayment. A request for a nonformulary appeal may be submitted in writing through the Disputed Claims Process as described in Section 8.

Why use generic drugs? Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.

Some drugs require prior authorization. Prior Authorization Requirements (PAR) are applied to encourage appropriate use of medications that are most likely to have certain risk factors. These requirements apply to drugs that may be used in amounts that exceed dosage or length of treatment recommendations or that may be more costly than medications that are proven to be clinically and therapeutically similar. If your prescription is identified as a drug requiring PAR, your physician should call Customer Service at 1-877-531-1159.

These are the dispensing limitations. When you obtain prescription drugs from a pharmacy using your Prescription Drug Card, you may obtain up to a 30-day supply of covered drugs. If purchasing more than a 30-day supply on the same day, any expense exceeding that supply limit will not be covered through the pharmacy arrangement. You may purchase your covered prescription drugs and supplies by presenting your prescription drug card and your prescription to a participating provider. Prescription refills will be covered when no more than 50% of the 30-day supply remains based on your physician's prescription.

If your physician or dentist prescribes a medication that will be taken over an extended period of time, you should request two (2) prescriptions, one for immediate use with a participating retail pharmacy and the other for up to a 90-day supply from the Mail Order Program. All drugs and supplies covered by the Plan are available under this program except fertility drugs. If you have questions about a particular drug or a prescription, and to request your first order forms, call 1-877-438-4449. If a generic equivalent to the prescribed drug is available, Express Scripts will dispense the generic equivalent instead of the brand name unless you or your physician specifies that the brand name is required. When purchasing drugs at a pharmacy, you must use your medical i.d. card.

Benefits Description	You Pay After the calendar year deductible...
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Covered medications and supplies	
<p>You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail:</p> <ul style="list-style-type: none"> • Drugs, vitamins and minerals that by Federal law of the United States require a doctor’s prescription for their purchase • Insulin and diabetic supplies <p><i>Note: Members with diabetes that have Medicare B as their primary insurer, must obtain their testing supplies through a diabetic supplier that coordinates benefits with Medicare. Please call the number on the back of your insurance card for assistance in identifying a supplier.</i></p> <ul style="list-style-type: none"> • FDA-approved drugs and devices requiring a physician’s prescription for the purpose of birth control that is not generic. See Section 5(a) Family planning • Needles and syringes for the administration of covered medications <p>Here are some things to keep in mind about our prescription drug program:</p> <ul style="list-style-type: none"> • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. Your physician must specify “dispense as written” if a brand name drug is required. • We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. To request a prescription drug formulary, call Customer Service at 1-877-438-4449. <p>Compound prescription drugs are covered as Level 3 drugs.</p>	<p>Network Retail:</p> <p>Level 1: \$5 (No Deductible)</p> <p>Level 2: \$35 (No Deductible)</p> <p>Level 3: 30% or \$50, whichever is greater (No Deductible)</p> <p>Network Retail when Medicare Part B is primary:</p> <p>Level 1: \$3 (No Deductible)</p> <p>Level 2: \$18 (No Deductible)</p> <p>Level 3: 30% or \$35, whichever is greater (No Deductible)</p> <p>Network Mail Order:</p> <p>Level 1: \$10 (No Deductible)</p> <p>Level 2: \$70 (No Deductible)</p> <p>Level 3: 30% or \$100, whichever is greater (No Deductible)</p> <p>Network Mail Order when Medicare Part B is primary:</p> <p>Level 1: \$6 (No Deductible)</p> <p>Level 2: \$36 (No Deductible)</p> <p>Level 3: 30% or \$45, whichever is greater (No Deductible)</p> <p>Note: If there is no generic equivalent available, you will still have to pay the Level 2 or Level 3 copay.</p> <p>When purchasing drugs at a pharmacy, you must use your Health Insurance Card.</p>
<p>Medications to treat severe, chronic medical conditions and are usually administered by injection or infusion in the following categories:</p>	<p>7% up to maximum of \$150 per 30 day supply (No Deductible)</p>

Covered medications and supplies - continued on next page

Benefits Description	You Pay After the calendar year deductible...
Covered medications and supplies (cont.)	
<ul style="list-style-type: none"> • Antihemophilic factors such as Helixate FS, Recombinate • Blood growth factors such as Aranesp, Leukine, Neupogen, Procrit • Calcimimetic Agent such as Sensipar • Growth Hormone medications such as Genotropin, Humatrope, Nutropin • Immunoglobulin preparations such as, Gamunex, Iveegam • Immunosuppressives such as Amevive, Copaxone, Raptiva • Interferons such as Avonex, Betaseron, Intron A, Pegasys, Peg-Intron • Interleukin-Receptor Antagonist such as Kineret • Monoclonal antibody such as Synagis, Xolair • Mucolytic Enzyme such as Pulmozyme • Platelet Aggregation Inhibitor such as Remodulin • Prostaglandin drugs such as Flolan • Synthetic Nucleoside Analog such as Copegus, Rebetol, Ribavirin • Tumor necrosis factor modulators such as Enbrel, Humira <p>Drugs in these categories are subject to the Specialty Pharmacy Benefits. The medication examples provided are not all inclusive. Call our Customer Service department at 1-877-531-1159 to determine if other medications not listed apply to this benefit.</p>	7% up to maximum of \$150 per 30 day supply (No Deductible)
<p>Obtaining Specialty Medication under the Plan:</p> <p>Please refer to your drug plan formulary to determine if the drug you have been prescribed by your physician needs to be filled by one of the Plan's Specialty Pharmacy providers.</p> <p>If your medication has been identified as being a specialty medication, you will be required to call the number on your insurance card for instructions on how to arrange the filling and delivery of your specialty medication.</p> <ul style="list-style-type: none"> • Medications will be mailed to you at no additional cost • For safety, all mailing will be shipped based on temperature requirements and considerations • Specialty Medications cannot be obtained through the traditional 90-day mail order program 	<p>7% up to maximum of \$150 per 30 day supply (No Deductible)</p> <p><i>Note: Specialty medications are not eligible for the mail order benefit of three months supply for two copayments.</i></p>

Covered medications and supplies - continued on next page

Benefits Description	You Pay After the calendar year deductible...
<p>Covered medications and supplies (cont.)</p> <ul style="list-style-type: none"> • Unless on an emergency basis, the Plan will not pay for Specialty Medications through the retail pharmacy. <p>Specialty medications are injectable and oral medications that are used to treat chronic health conditions including but not limited to such conditions as transplant recipients, immunological conditions, growth hormone, bleeding disorder, HIV/AIDS.</p>	<p>7% up to maximum of \$150 per 30 day supply (No Deductible)</p> <p><i>Note: Specialty medications are not eligible for the mail order benefit of three months supply for two copayments.</i></p>
<p>If you reside outside of the United States and do not order prescription drugs through the Mail Order Prescription Drug Program</p> <p>If you are provided drugs, including specialty pharmacy drugs, directly by a physician or covered facility (not a pharmacy), including FDA-approved drugs and devices requiring a physician’s prescription for the purpose of birth control</p> <p>If you do not use your prescription drug card to purchase needles and syringes for the administration of covered medications or diabetic supplies</p> <p>If you purchase colostomy or ostomy supplies</p>	<p>20% of the total cost of the drug</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Nutritional supplements and vitamins (including prenatal) that do not require a prescription</i> • <i>Medication that does not require a prescription under Federal law even if your physician prescribes it or a prescription is required under your State law</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Medication for which there is a non-prescription equivalent available. Prescriptions received from non-participating pharmacies unless overseas or through a covered physician or facility. (Call 1-877-438-4449 to locate a participating pharmacy.)</i> • <i>Drug copayments</i> • <i>Fertility drugs are covered only under “Infertility services” in Section 5(a)</i> <p><i>Note: Physician prescribed over-the-counter or prescription drugs approved by the FDA to treat tobacco dependence are covered under the Smoking cessation benefit. (See page 39).</i></p>	<p><i>All charges</i></p>

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 *Coordinating benefits with other coverage, including with Medicare*.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible does not apply to the benefits in this Section. We added - (No Deductible) - to show that the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.

Note: Even when the dental procedure itself may not be covered, we cover hospitalization for dental procedures when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for outpatient hospital benefits.

Accidental injury benefit	You Pay
<p>Accidental injury benefit</p> <p>We cover outpatient restorative services necessary to promptly repair (but not replace) sound natural teeth until treatment is completed.</p> <p>The need for these services must result from an accidental injury from an external force such as a blow or fall that requires immediate attention (not from biting or chewing).</p>	<p>20% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible)</p>

Dental Benefits		
Service	We pay (scheduled allowance)	You Pay
<p>Routine oral examinations including x-rays, cleaning, diagnosis, and preparation of a treatment plan</p> <p>Dental fillings:</p> <ul style="list-style-type: none"> • One Surface • Two Surface • Three or more surfaces 	<p>\$39 twice per year</p> <p>\$12</p> <p>\$19</p> <p>\$24</p>	<p>All charges in excess of the scheduled amounts listed to the left (No Deductible)</p>

Not Covered

- *Dental appliances, study models, splints, and other devices or dental services associated with the treatment of temporomandibular joint (TMJ) dysfunction*
- *Root canals and crowns (except for accidental dental injury benefit)*
- *Other dental services not listed as covered*

Note: Surgical removal of impacted teeth is covered in Section 5(b).

Section 5(h). Special features

Special feature	Description
Flexible Benefits Option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Centers of Excellence	<p>The Plan has special arrangements with facilities to provide services for tissue, organ transplants and bariatric surgery. The network was designed to give you an opportunity to access providers that demonstrate high quality medical care for transplant and bariatric patients. For additional information regarding our transplant network and bariatric network, please call 1-877-531-1159.</p>
Medical Management	<p>This Plan offers a medical management program for members and covered dependents with diabetes, heart failure, asthma, coronary artery disease, or chronic obstructive pulmonary disease. Your health is important to us! If you or your covered dependent has any of the above, you will be contacted to voluntarily participate.</p> <p>If you would like more information about this program, please call your plan at 1-877-531-1159.</p>
Lifestyle Prescription Medications	<p>Many lifestyle prescription drugs are available at a discounted rate through participating pharmacies and the Plan's mail order program. You are responsible for the entire cost of the drugs; however, they are available to you at our preferred contracted rate. The following lifestyle prescription drugs are covered under this benefit:</p> <p>Cosmetic: Renova, Vaniqua, Propecia</p> <p>Infertility: A.P.L., Chorex-5, Chorex-10, Chronon 10, Clomid, Clomiphene, Crinone gel, Fertinex, Follistem, Gonal-F, Gonic, HCG, Humegon, Pergonal, Pregnyl, Profasi, Repronex, Serophone</p> <p>Obesity: Adipost, Didrex, Ionamin, Merida, Phendimetrazine, Phenter mine, Sanorex, Tenuate, Xenical</p> <p>Sexual Dysfunction: Caverject, Edex, Muse, Viagra, Cialis</p>

	<p>This list is subject to change and may be subject to medical necessity review if they are covered under another benefit provision (i.e., infertility).</p> <p>If you have a question on drug coverage, call 1-877-531-1159.</p>
Services Overseas	<p>Our overseas customers receive the same in-network benefits and prompt customer service as their stateside counterparts. There is no additional claims processing time for foreign claims.</p>
The LabCorp Program	<p>This program gives you and your dependents the option of receiving 100% covered outpatient laboratory testing if your doctor sends your lab work to LabCorp for processing.</p> <p>This is an optional program. If you choose not to use the Lab Program, you will not be penalized. You will simply pay the deductible, coinsurance or copay portion of your lab work.</p> <p>The Lab Program does not replace your current healthcare benefits; it simply gives you and your covered family members the option of receiving 100% coverage for outpatient laboratory testing.</p> <p>The Lab Program covers most outpatient laboratory testing included in your health insurance plan provided the tests have been ordered by a physician and processed at the designated labs. Outpatient lab work includes: Blood testing (e.g., cholesterol, CBC), Urine testing (e.g., urinalysis), Cytology and pathology (e.g., pap smears, biopsies), Cultures (e.g., throat culture).</p> <p>The LabCorp Program does not cover: lab work ordered during hospitalization, lab work needed on an emergency (STAT) basis and time sensitive, esoteric outpatient laboratory testing such as fertility testing, bone marrow studies and spinal fluid tests, non laboratory work such as mammography, x-ray, imaging and dental work.</p> <p>When Medicare is primary, the Program does not apply.</p>

Section 5(i). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 1-866-368-7227, or visit our website at www.compassrosebenefits.com.

Careington International Corporation

Take advantage of the savings with Careington's professional Dental and Vision Discount network.

- Dental network of over 133,000 dental access points. Save on most dental procedures including routine oral exams, unlimited cleanings and major works such as dentures, root canals and crowns. All specialties are included - Endodontics, Oral Surgery, Orthodontics, Pediatric Dentistry, Periodontics and Prosthodontics where available. Careington also offers a discount shopping program with retailers that include discounts on teeth whitening kits, you may visit www.careingtonmall.com to discover the possible savings. Contact Careington at 800-290-0523 for further details and make sure to identify yourself as a **DFG** member. If your selected vision provider also participates with Careington, you may be eligible for additional benefits through the following companies.

VSP Choice Access Plan

- Access more than 41,000 participating providers nationwide. Save 15% to 35% on eye exams, eyeglasses and contact lenses. Product not available in MT, VT and WA.

EyeMed

- Members are eligible for discounts up to 20% to 40% off the retail price of eyewear. Eye exams, eyeglasses and contact lenses are also discounted with EyeMed Vision Care Access Plan D. More than 50,000 providers nationwide including independent optometrists, ophthalmologists, opticians and leading optical retailers.

LCA

- LASIK eye surgery through the National Lasik Network with over 570 locations nationwide. 15% off retail price or 5% off the promotional price of LASIK procedures.

QuailSight LASIK

- You will receive a free consultation to discuss the procedures available, and a preliminary screening to determine if you are a potential candidate. You can save 40% to 50% on LASIK vision correction surgery and access a network of over 850 locations nationwide.

To view Careington's disclosure guidelines for the Careington Dental, VSP, EyeMed, LCA and QuailSight services, please visit www.compassrosebenefits.com/careington.

GlobalFit Discount Program

GlobalFit offers a full range of affordable options for you to get fit, feel more energized, and live a healthier lifestyle. GlobalFit offers you and your covered dependents:

Gym Memberships

- Guaranteed lowest rates on full-access memberships, the same as if you paid full retail price
- 10,000 locations nationwide, including 24-Hour Fitness, Bally, Curves, and Anytime Fitness, plus regional chains and local favorites
- Free Guest Passes to try most gyms before joining
- A range of membership options to fit your needs

Or visit the *GlobalFit Store* for exclusive member savings on these at-home options:

- Zumba® DVDs: join the Latin-inspired fitness party at a special low price
- Total Gym®: 15% off the popular body-weight trainer, plus exclusive savings on other home fitness equipment
- Exercise On Demand: easy-to-follow online workout videos with scheduling/tracking tools
- bodybugg®: the calorie-management system used on NBC's *The Biggest Loser*, with GlobalFit's exclusive low price
- Nutrisystem®: \$30.00 off their best advertised price for home-delivered, portion-controlled meals
- Dr. Will Clower's Mediterranean Wellness: an 8-week program with daily coaching and recipes, plus unlimited counseling, to meet your goals with *real* food
- Virtual Meal Planner: set and meet weight goals with balanced nutrition, starting with the foods you love
- Health Coaching: confidential, one-on-one phone access to a health professional to help you quit smoking, lose weight, self-care for diagnosed conditions, or meet other goals.

To enroll, or learn more about this discount benefit, contact a GlobalFit Representative at 800 294-1500, option 1 or visit www.compassrosebenefits.com/GlobalFit.

US Imaging

US Imaging offers a voluntary, VIP appointment-scheduling program for your advanced diagnostic imaging tests, such as MRI, CT, and PET scans. US Imaging is able to obtain appointments for Compass Rose Health Plan members at a high quality and accredited in-network facility of your choice, which may save you hundreds of dollars on your out-of-pocket costs. This program is not applicable to members with Medicare A and B. When your doctor orders one of these scans, simply call US Imaging at 877-904-1877 and they will:

Provide you with VIP concierge scheduling

- US Imaging will schedule your test at a facility close to you within 24 to 48 hours and take care of all the details for you

Locate a high quality facility near you

- Facilities have state-of-the-art equipment and meet top imaging standards

Immediate savings

- You may save hundreds of dollars on your out-of-pocket costs

Remember, you *already* have access to this program at no additional cost to you. It is specifically designed to save you money and alleviate the hassle of scheduling your radiology scans. For more information on the VIP program visit www.compassrosebenefits.com/USImaging or call 877-904-1877.

Cobalt Health Care/COBRA alternative and TCC option

This plan is a more affordable option to COBRA/TCC for those who are no longer eligible for coverage under FEHB plan. It is a simple and flexible alternative. For information visit www.compassrosebenefits.com/Cobalt.

New York Life Group Term Life Insurance

The Compass Rose Group Term Life Insurance Plan, underwritten by New York Life Insurance Company (New York, NY 10010)*, caters exclusively to the unique needs of active Federal employees. Some highlights of our affordable plan include:

- Full and Immediate Worldwide Coverage for Acts of War and Terrorism
- New Employees: Up to \$250,000 in Guaranteed Issue Coverage and up to \$50,000 in Guaranteed Issue Supplemental Spouse Coverage available during the first 60 days of employment - no medical questions.
- Up to \$500,000 in Employee and \$100,000 in Supplemental Spouse Coverage and simplified medical underwriting - only three questions.
- \$10,000 Spouse and Dependent Child (under age 22) Life Coverage automatically included

- Up to \$100,000 in Accidental Death and Dismemberment (AD&D) Coverage automatically included – including loss due to Acts of War if you are there at the direction of your employer.
- Coverage amounts not linked to employee salary
- Our plan is portable and can be taken with you even if you leave your current employer

To learn more about our Group Term Life Insurance Plan, including plan features, costs, eligibility, limitations and renewal provisions, or to request a brochure, visit www.compassrosebenefits.com/TermLife.

*Policy Form GMR-ER-P

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Group Accident Plan

The Compass Rose Group Accident Plan (GAP), underwritten by Nationwide Insurance Company, is designed to provide a financial benefit in case of a death or dismemberment caused by an accident. Highlights of the plan include:

- Full and Immediate Worldwide Coverage for Acts of War and Terrorism
- Includes coverage for loss of life, limbs, hearing, vision + paralysis, and other covered losses
- NO medical underwriting
- \$150,000 - \$500,000 in Coverage
- Affordable rates for either Employee Only Coverage or Family Coverage

To learn more about GAP, visit www.compassrosebenefits.com/GAP.

The 20•20 Foundation

The 20•20 Foundation can help members preserve life and provide a helping hand to those who protect this nation's freedoms. For a modest \$20 annual premium, you and your covered colleagues will receive protection in the amount of \$20,000 in the event of a serious injury or accidental death. Coverage is extended for both business and leisure, even if injury or death is sustained through an Act of War or Terrorism anywhere in the world. The Foundation's benefits assist with financial shortages such as:

- Mortgage payments
- Tuition costs
- Modifications to a home or car for those who are paralyzed or dismembered
- Rehabilitation needs
- Any other necessary financial obligations
- \$20,000, \$50,000, \$100,000 In Coverage

To enroll, or learn more about The Foundation, visit www.compassrosebenefits.com/2020. Federal retirees and contractors are not eligible to enroll.

Travel Guard Silver Plan

The Travel Guard Silver Plan through Travel Guard provides per trip travel insurance, with Trip Cancellation Coverage, which is specifically tailored to each individual trip cost and age of each traveler. Trip Cancellation Coverage provides reimbursements for pre-paid, non-refundable expenses such as airline tickets, cruises, vacation packages, and even vacation rental homes when cancellation is due to a covered reason. There are no eligibility restrictions to enroll in this plan. Travel Guard Silver benefits include:

- Trip Cancellation: 100% of insured trip cost
- Trip Interruption: 100% of insured trip cost
- Trip Interruption – Return Air Only: \$500

- Trip Delay: \$500 with a maximum of \$100 per day
- Baggage and Personal Effects Loss: \$750 (\$50 deductible)
- Baggage Delay: \$200
- Medical Expense: \$15,000 (\$50 deductible)
- Emergency Evacuation/Repatriation of Remains: \$150,000
- Family Coverage: One child age 17 and under will receive coverage at no additional cost for each adult who purchases the plan.

To take advantage of Travel Guard Silver, visit www.compassrosebenefits.com/Travel or call our dedicated Compass Rose Travel Guard Insurance Desk at 866-420-9985.

* This is only a brief description of the coverage(s) available. Full details of coverage are contained in the policy.

NON-FEHB Benefits are not part of the FEHB contract.

Section 6. General Exclusions - services, drugs and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition (see specifics regarding transplants).** The fact that one of our covered providers has prescribed, recommended, or approved a service or supply does not make it medically necessary or eligible for coverage under this Plan.

For information on obtaining prior approval for specific services, such as transplants, (see Section 3 *When you need prior Plan approval for certain services*).

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations, sexual dysfunction or sexual inadequacy;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program
- Services, drugs, or supplies you receive without charge while in active military service.
- Any portion of a provider's fee or charge that has been waived. If a provider routinely waives (does not require you to pay) a deductible, copayment or coinsurance, we will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived).
- Charges you or the Plan has no legal obligation to pay, such as excess charges for an annuitant 65 years or older who is not covered by Medicare Part A and/or Part B, physician charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge), or State premium taxes however applied;
- Services, drugs, or supplies for which you would not be charged if you had no health insurance coverage;
- Drugs and supplies related to weight control or any treatment of obesity except surgery for morbid obesity or nutritional counseling as described in Section 5 (a&b)
- Services, drugs or supplies you receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister by blood, marriage or adoption.
- The Plan does not cover expenses related to medical records submission if the medical records are needed to process a claim. If medical records are inappropriately requested, the charges can be covered.

Listed below are examples of some of our exclusions:

- Acupuncture, except when used as an anesthetic agent for covered services;
- Biofeedback, conjoint therapy, hypnotherapy, milieu therapy, and interpretation/preparation of reports;
- Charges for completion of reports or forms;
- Charges for interest on unpaid balances;
- Charges for missed or canceled appointments;
- Charges for telephone consultations, conferences, or treatment, mailings, faxes, emails or any other communication to or from a hospital or covered provider;
- Custodial care;

- Mutually exclusive procedures. These are procedures that are not typically provided to you on the same date of service;
- Non-medical services such as social services, recreational, educational and visual.
- Non-surgical treatment of temporomandibular joint (TMJ) dysfunction including dental appliances, study models, splints and other devices;
- Services, drugs or supplies not specifically listed as covered; and
- Treatment for learning disabilities including Applied Behavior Analysis (ABA) and mental retardation.
- "Never Events" are errors in patient care that can and should be prevented. We will follow the policy of the Centers for Medicare and Medicaid Service (CMS). The Plan will not cover care that falls under these policies. For additional information, visit www.cms.gov, enter Never Events into Search.
- The Plan does not cover research costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.

Note: Exclusions that are primarily identified with a specific benefit category may also apply to other categories.

Section 7. Filing a claim for covered services

How to claim benefits

To obtain claim forms, claims filing advice or answers about our benefits, contact us at 1-877-531-1159, or at our website at www.compassrosebenefits.com.

In most cases, providers and facilities file claims for you. Your physician must file on the form CMS-1500 or a claim form. Your facility will file on the UB-04 form. For claims questions and assistance, call us at 1-877-531-1159.

When you must file a claim—such as for services you received overseas or when another group health plan is primary—submit it on the CMS-1500 or a claim form that includes the information shown below. Itemized bills and receipts should be sent to Compass Rose Health Plan, PO Box 141501, Nashville, TN 37214.

- Patient's name, date of birth, address, phone number and relationship to enrollee
- Patient's Plan identification number
- Name and address of person or company providing the service or supply
- Dates that services or supplies were furnished
- Diagnosis
- Type of each service or supply
- Charge for each service or supply

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

In addition:

- If another health plan is your primary payor, you must send a copy of the explanation of benefits (EOB) form you received from your primary payor (such as the Medicare Summary Notice (MSN)) with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- If your claim is for the rental or purchase of durable medical equipment; private duty nursing; and physical therapy, occupational therapy, or speech therapy, you must provide a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies must include receipts that show the prescription number, name of drug or supply, prescribing physician's name, date, and charge.
- We will provide translation and currency conversion services for claims for overseas (foreign) services.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Records	Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.
Deadline for filing your claim	Send us all the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the re-issuance of uncashed checks.
Overseas claims	For covered services you receive in hospitals outside the United States and Puerto Rico and performed by physicians outside the United States, send a completed Claim Form and the itemized bills to: Compass Rose Health Plan P.O. Box 141501 Nashville, TN 37214 or fax to 410-626-8214. Obtain Claim Forms from: www.compassrosebenefits.com/claimform . If you have questions about the processing of overseas claims, contact 1-877-531-1159.
When we need more information	Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice Requirements	<p>The Secretary of Health and Human Services has identified counties where at least 10 percent of the population is literate only in certain non-English languages. The non-English languages meeting this threshold in certain counties are Spanish, Chinese, Navajo and Tagalog. If you live in one of these counties, we will provide language assistance in the applicable non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.</p> <p>Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes and its correspondence meaning, and the treatment code and its corresponding meaning).</p>

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.opm.gov.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing: Compass Rose Health Plan P.O. Box 141501 Nashville, TN 37214 or calling 1-877-531-1159.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">a) Write to us within 6 months from the date of our decision; andb) Send your request to us at: Compass Rose Health Plan PO Box 141501 Nashville, TN 37214c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andd) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. <p>We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.</p>
2	<p>In the case of a post-service claim, we have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none">a) Pay the claim or

- b) Write to you and maintain our denial or
- c) Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

If you do not agree with our decision, you may ask OPM to review it.

3

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 2, 1900 E Street, NW, Washington, DC 20415.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4

OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 1-877-531-1159. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 2 at 202-606-3818 between 8 a.m. and 5 p.m. eastern time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependant is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Worker's Compensation programs if you are receiving Worker's Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage".

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC web site at <http://www.NAIC.org>.

When we are the primary payor, we will pay the benefits described in this brochure,

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

Please see Section 4, *Your costs for covered services*, for more information about how we pay claims.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and the retirees of the military. TRICARE includes the CHAMPVA program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally, you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar preceding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State sponsored program of medical assistance. If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP)

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan:

Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor visits, lab test, x-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy (Page 28)
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials, this plan does not cover these costs.

When you have Medicare

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older;
- Some people with disabilities under 65 years of age;
- People with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (TTY 1-800-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits three months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 (TTY 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every twelve months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within eight months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

Please refer to page 80 for information about how we provide benefits when you are age 65 or older and do not have Medicare.

The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan: You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claims, call us at 1-877-531-1159.

We waive some costs when the Original Medicare Plan is your primary payor. We will waive some out-of-pocket costs, as follows:

- If you are enrolled in Medicare Part B, we will waive calendar year deductible, copayments and coinsurance for medical services and supplies provided by physicians and other health care professionals. We will also waive deductibles and coinsurance for extended dental treatment for accidental dental injuries.
- If you are enrolled in Medicare Part A, we will waive hospital copayments and coinsurance.

You can find more information about how our plan coordinates benefits with Medicare in the Compass Rose Health Plan brochure at www.compassrosebenefits.com.

Tell Us About Your Medicare Coverage

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

Private contract with your physician

A physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment. You may be responsible for paying the difference between the billed amount and the amount we paid.

Medicare Advantage (Part C)

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY 1-800-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB Plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage Plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

Medicare prescription drug coverage (Part D)

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payor for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓ *	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD (for 30 month coordination period)		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD (for the 30 month coordination period)		✓
• Medicare based on ESRD (after the 30 month coordination period)	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

When you are age 65 or over and you do NOT have Medicare

Under the FEHB law, we must limit our payments for inpatient hospital care and physician care to those payments you would be entitled to if you had Medicare. Your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the FEHB benefit from these payment limits. Outpatient hospital care and non-physician based care are not covered by this law; regular Plan benefits apply. The chart on page 79 has more information about the limits.

If you:

- are age 65 or over; and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant or as a former spouse, or as a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB coverage. (Your employing office can tell you if this applies.)

Then, for your inpatient hospital care:

- The law requires us to base our payment on an amount—the “equivalent Medicare amount”—set by Medicare’s rules for what Medicare would pay, not on the actual charge.
- You are responsible for your applicable deductibles, coinsurance, or copayments under this Plan.
- You are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you.
- The law prohibits a hospital from collecting more than the "equivalent Medicare amount."

And, for your physician care, the law requires us to base our payment and your coinsurance or copayment on:

- an amount set by Medicare and called the “Medicare approved amount,” or
- the actual charge if it is lower than the Medicare approved amount.

If your physician:	Then you are responsible for:
Participates with Medicare or accepts Medicare assignment for the claim and is a member of our PPO network,	your deductibles, coinsurance, copayments.
Participates with Medicare and is not in our PPO network,	your deductibles, coinsurance, copayments, and any balance up to the Medicare approved amount.
Does not participate with Medicare,	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount.

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are permitted to collect only up to the Medicare approved amount.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us at 877-531-1159.

When you have the Original Medicare Plan (Part A, Part B, or both)

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare A (Hospital insurance) and Medicare B (Medical insurance), regardless of whether Medicare pays. *Note: We pay our regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.*

We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the statement is submitted to determine our payment for covered services provided to you if Medicare does not pay the VA facility.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

If your physician accepts Medicare assignment, then you pay nothing for covered charges.

If your physician does not accept Medicare assignment, then you pay the difference between the “limiting charge” or the physician’s charge (whichever is less) and our payment combined with Medicare’s payment.

It’s important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the “limiting charge.” The Medicare Summary Notice (MSN) that Medicare will send you will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to the Medicare carrier that sent you the MSN form. Call us if you need further assistance.

Section 10. Definitions of terms we use in this brochure

Admission	The period from entry (admission) into a hospital or other covered facility until discharge. In counting days of inpatient care, the date of entry and the date of discharge are counted as the same day.
Assignment	Your authorization for the Plan to issue payment of benefits directly to the provider. We reserve the right to pay the member directly for all covered services.
Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Clinical trials cost categories	<p>If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:</p> <ul style="list-style-type: none">• Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient’s condition, whether the patient is in a clinical trial or is receiving standard therapy.• Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient’s routine care.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 21.
Congenital anomalies	A condition existing at or from birth that is a significant deviation from the common form or anomaly norm. For purposes of this Plan, congenital includes protruding ear deformities, cleft lips, cleft palates, webbed fingers or toes, and other conditions that we may determine to be congenital anomalies. In no event will the term congenital anomaly include conditions relating to teeth or intra-oral structures supporting the teeth.
Copayment	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive covered services. See page 21.
Cosmetic surgery	Any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through a change in bodily form.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Services we provide benefits for, as described in this brochure.
Custodial care	<p>Treatment or services, regardless of who recommends them or where they are provided, that could be provided safely and reasonably by a person who is not medically skilled, or are designed mainly to help the patient with daily living activities. These activities include but are not limited to:</p> <ol style="list-style-type: none">1) personal care such as help in: walking; getting in or out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;2) homemaking, such as preparing meals or special diets;3) moving the patient;4) acting as a companion or sitter;5) supervising medication that can usually be self administered; or6) treatment services such as recording temperature, pulse, and respirations, or administration and monitoring of feeding systems. <p>Custodial care that lasts 90 days or more is sometimes known as Long Term Care.</p>

Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 21.
Effective date	The date the benefits described in this brochure are effective: <ol style="list-style-type: none"> 1. January 1 for continuing enrollments and for all annuitant enrollments; 2. the first day of the first full pay period of the new year for enrollees who change plans or options or elect FEHB coverage during Open Season for the first time; or 3. for new enrollees during the calendar year, but not during Open Season, the effective date of enrollment as determined by your employing office or retirement system.
Expense	The cost incurred for a covered service or supply ordered or prescribed by a covered provider. You can incur an expense on the date the service or supply is received. Expense does not include any charge: <ol style="list-style-type: none"> 1. for a service or supply that is not medically necessary; or 2. that is in excess of the Plan's allowance for the service or supply.
Experimental or investigational services	A drug, device, or biological product is experimental or investigational if it cannot lawfully be marketed without approval of the U.S. Food and Drug Administration (FDA), and approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA. <p>A medical treatment or procedure, or a drug, device, or biological product is experimental or investigational if 1) reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.</p> <p>Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.</p>
Group Health Coverage	Health care coverage that you are eligible for because of employment, membership in, or connection with, a particular organization or group that provides payment for hospital, medical or other health care service or supplies, or that pays a specific amount for each day or period hospitalization.
Health care professional	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.
Home health care agency	A public or private agency or organization appropriately licensed, qualified and operated under the law of the state in which it is located.
Home health care plan	A written plan, approved in writing by a physician, for continued care and treatment for a Plan member who is under the care of a physician and who would need a continued stay in a hospital or skilled nursing facility with the home health care.
Hospice care program	A coordinated program of home and inpatient pain control and supportive care for the terminally ill patient and the patient's family. Care is provided by a medically supervised team under the direction of an independent hospice administration that we approve.
Hospital stay	An admission (or series of admissions separated by less than 60 days) to a hospital as an inpatient for any one illness or injury. There is a new hospital stay when an admission is:

1. for a cause entirely unrelated to the cause for the previous admission;
2. for an enrolled employee who returns to work for at least one day before the next admission; or
3. for a dependent or annuitant when hospital stays are separated by at least 60 days.

Intensive Outpatient Program (IOP)

A program that offers time-limited services that are coordinated, structured, and intensively therapeutic. Such programs are designed to treat a variety of individuals with moderate to marked impairment in at least one area of daily life resulting from psychiatric or addictive disorders. At a minimum, IOPs offer three to four hours of active treatment per day at least two to three days per week.

Long term rehabilitation therapy

Physical, speech, and occupational therapy which can be expected to last longer than a two-month period in order to achieve a significant improvement in your condition.

Medical necessity

Services, drugs, supplies, or equipment provided by a hospital or covered provider of health care services that we determine:

- 1) are appropriate to diagnose or treat your condition, illness or injury;
- 2) are consistent with standards of good medical practice in the United States;
- 3) are not primarily for the personal comfort of the patient, the family, or the provider;
- 4) are not a part of or associated with the scholastic education or vocational training of the patient; and
- 5) in the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug or equipment does not in itself make it medically necessary.

**Mental conditions/
substance abuse**

Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD to be determined by the Plan; or disorders listed in the ICD requiring treatment for abuse of or dependence upon substances such as alcohol, narcotics, or hallucinogens.

Partial hospitalization

A time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services with a stable therapeutic environment. It provides 20 hours of scheduled programming, extended over a minimum of five days per week, by a licensed or JCAHO accredited facility

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowance in different ways. We determine our allowances as follows:

PPO Providers - Our Plan allowance is a negotiated amount between the Plan and the provider. We base our coinsurance on this negotiated amount, and the provider has agreed to accept the negotiated amount as full payment for any covered services rendered. This applies to all benefits in Section 5 of this brochure. **Please note that the PPO benefit also applies to providers used outside the 50 United States.**

Non-PPO Providers - Our Plan allowance is the lesser of: (1) the providers' billed charge; or (2) the Plan's out-of-network (OON) fee schedule amount. The Plan's OON fee schedule amount is equal to the 90th percentile amount for the charges listed in the Prevailing Healthcare Charges System (or its successor) utilized by the Plan's underwriter. The OON fee schedule amounts vary by geographic area in which services are furnished. We base our coinsurance on this OON fee schedule amount. This applies to all benefits in Section 5 of this brochure.

For certain services, exceptions may exist to the use of the OON fee schedule to determine the Plan's allowance for non-PPO providers, including, but not limited to, the use of Medicare fee schedule amounts. For claims governed by OBRA '90 and '93, the Plan allowance will be based on Medicare allowable amounts as is required by law. For claims where the Plan is the secondary payor to Medicare (Medicare COB situations), the Plan allowance is the Medicare allowable charge.

For more information, see Section 4, *Differences between our allowance and the bill*.

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Prosthetic device An artificial substitute for a missing functional body part (such as an arm or leg) because the body part is permanently damaged, is absent or is malfunctioning.

Routine physical examination A complete evaluation, including a comprehensive history and physical examination, without symptoms or illness.

Routine testing/screening Healthcare services you receive from a covered provider without any apparent signs or symptoms of an illness, injury or disease.

Sound natural tooth A tooth that is whole or properly restored and is without impairment, periodontal, or other conditions and is not in need of the treatment provided for any other reason other than an accidental injury.

Urgent care claims A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve pre-service claims and not post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at Compass Rose Health Plan PO Box 141501 Nashville, TN 37214 or call us at 1-877-531-1159. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We Us and we refer to the Compass Rose Health Plan.

You You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

"Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no Government contribution."

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – FSAFEDS

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is \$2,500.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, and **physician prescribed** over-the-counter medication over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance. FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider file claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program- FEDVIP

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.** FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including all the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period, for dependent children up to age 19.

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/vision and www.opm.gov/insure/dental. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888- 3337 (TTY 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

The Pre-Existing Condition Insurance Program - *PCIP*

- **Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.** An individual is eligible to buy coverage in PCIP if:
 - He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
 - He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.);
 - He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY): 1-866-561-1604.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of benefits for the Compass Rose Health Plan- 2013

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the \$350 PPO and \$400 non-PPO calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a non-PPO physician or other health care professional.

High Option Benefits	You pay	Page
Diagnostic and treatment services provided in the office	PPO: \$15 co-payment (No Deductible) \$25 co-payment for Specialist (No Deductible) *Non-PPO: 30% of our Plan allowance \$15 co-payment (No Deductible) for providers used outside of the 50 United States \$25 co-payment for Specialist (No Deductible) used outside the 50 United States	28
Surgery	PPO: 10% of our allowance Non-PPO: 30% of our plan allowance 10% of our allowance for providers used outside the 50 United States	40-41
Services provided by a hospital:		
<ul style="list-style-type: none"> • Inpatient 	PPO: \$200 hospital stay (No Deductible) Non-PPO: \$400 hospital stay and 30% of our plan allowance (No Deductible) \$200 hospital stay (No Deductible) for providers used outside the 50 United States	48-49
<ul style="list-style-type: none"> • Outpatient 	*PPO: 10% of our allowance *Non-PPO: 30% of our plan allowance *10% of our allowance for providers used outside the 50 United States	49-50
Emergency benefits:		
<ul style="list-style-type: none"> • Accidental Injury • For Emergency Room (ER) facility charge or ER physician's charge or ER physician's charge or initial office visit • Regular benefits for x-ray, lab, pathology, and machine diagnostic test. 	PPO: In physician's office \$15 copay \$25 in specialist's office. Outside physician's office \$100 copay per occurrence (No Deductible). Non-PPO: \$100 copay per occurrence (No Deductible)	51-52

	In physician's office \$15 copay. In Specialist office \$25. Outside physician's office \$100 copay per occurrence (No Deductible) for providers outside the 50 United States	
<ul style="list-style-type: none"> • Urgent Care <p>If you receive outpatient care for your accidental and medical emergency injury in an urgent care center, we cover</p> <ul style="list-style-type: none"> - Non-surgical physician services and supplies - Surgery and related services 	The member will pay a \$50 copayment per occurrence for services provided at urgent care centers, no deductible for PPO, this includes providers used outside the 50 United States	51-52
<ul style="list-style-type: none"> • Medical emergency <p>Regular Plan benefits apply except for the copays listed on the right when you receive care because of a non-accidental medical emergency. See Section 5(a).</p>	<p>PPO services in physician's office: \$15 copayment</p> <p>\$25 copayment in Specialist's office (No Deductible). This includes providers used outside the 50 United States</p> <p>PPO services outside physician's office: \$100 copay per occurrence and 10% of the Plan allowance (copay is waived if admitted to the hospital). No Deductible (Please note that the use of an Urgent Care Facility would be a \$50 copay instead of a \$100 copay) This includes providers used outside the 50 United States</p> <p>Non-PPO: \$100 copay per occurrence and 10% of the Plan allowance (copay is waived if admitted to the hospital). No Deductible</p>	52
Mental health and substance abuse treatment	<p>PPO: Regular cost sharing.</p> <p>Non-PPO: Regular cost sharing</p> <p>Regular cost-sharing for providers used outside the 50 United States</p>	54-55
Prescription drugs	<p>Network Retail: Level 1: \$5 (No Deductible), Level 2: \$35 (No Deductible), Level 3: 30% or \$50, whichever is greater (No Deductible)</p> <p>Network Mail Order: Level 1: \$10 (No Deductible), Level 2: \$70 (No Deductible), Level 3: 30% or \$100, whichever is greater (No Deductible)</p> <p>Network Retail when Medicare Part B is primary: Level 1: \$3 (No Deductible), Level 2: \$18 (No Deductible), Level 3: 30% or \$35, whichever is greater (No Deductible)</p>	56-59

	<p>Network Mail Order when Medicare Part B is primary: Level 1: \$6 (No Deductible), Level 2: \$36 (No Deductible), Level 3: 30% or \$45, whichever is greater (No Deductible)</p> <p><i>Note: If there is no generic equivalent available, you will still have to pay the Level 2 copay.</i></p> <p>Specialty Medications must be received through one of our Specialty Pharmacy Providers to receive the retail benefit. There is no benefit if other providers are used. Please contact 1-877-988-0057 for more information.</p>	
Dental care	Routine exams and fillings; fee schedule	60
Special features	<p>Center of Excellence</p> <p>Medical Management Program</p> <p>Flexible benefits option</p> <p>Lifestyle prescription medications</p> <p>Services overseas</p> <p>The LabCorp Program</p>	61-62
Protection against catastrophic costs (out-of-pocket maximum)	<p>PPO: Nothing after \$4,000/Self Only or Family enrollment per year</p> <p>Non-PPO: Nothing after \$7,000/Self Only or Family enrollment per year</p> <p>Nothing after \$4000/Self Only or Family enrollment per year for providers used outside the 50 United States</p>	23

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2013 Rate Information for Compass Rose Health Plan

FEHB benefits of this Plan are described in the Compass Rose Health Plan Brochure

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Type of Enrollment	Enrollment Code	Non-Postal Premium			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
High Option Self Only	421	\$190.84	\$71.34	\$413.49	\$154.57
High Option Self and Family	422	\$424.95	\$177.78	\$920.73	\$385.19